

10611

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 60 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAZEL Middle ELIZABETH Last BAKER		4. DATE OF DEATH Month SEPTEMBER Day 16 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY SHOE FACTORY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OLIVER BAKER		14. MOTHER'S MAIDEN NAME SARAH BYREM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-5543	
17. INFORMANT MRS. EVA HOELLE Address HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 days Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 14, 1958 , to April 16, 1958 , that I last saw the deceased alive on Sept. 16, 1958 , and that death occurred at 3:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 145 W. Washington DATE SIGNED 9/17/58 ACTUAL SIGNATURE L. L. Packer Jr. M.D. PHYSICIAN'S NAME (Type) L. L. Packer Jr. Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/18/58	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE SEP 19 '58 24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10605

10612

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMY Middle CORDELIA Last BELL		4. DATE OF DEATH Month Sept. Day 16 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Fairview Wash. Co., Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry B. Leshner		14. MOTHER'S MAIDEN NAME Mary Ellen Stine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Virginia Lore - Solomons		Address Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Myocardial Heart Disease 420.1 DUE TO Acute Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-58	
22c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Near Clearspring Wash., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown, Md	
24a. REC'D BY REGISTRAR DATE SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10606

10675

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weverton			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weverton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -				d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Grace Middle W Last Bingham				4. DATE OF DEATH Month 9 Day 18 Year 1958				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/21/86		
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fitter			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME David H. Bingham				14. MOTHER'S MAIDEN NAME Mary Merryman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Margaret J. Bingham		Address Knoxville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 Malignancy gastro-intestinal tract, with metastasis, origin and type unknown DUE TO (b) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) - DUE TO (c) -							INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease with hypertension and congestive failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. -		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Knoxville		(County) -		(State) -		
21. I certify that I attended the deceased from July 1955 to 18 Sept. 1958 , that I last saw the deceased alive on 14 Sept. 1958 , and that death occurred at M. from the causes and on the date stated above.								
ACTUAL SIGNATURE Charles H. Conley Jr.		M.D. Professional Bldg.		ADDRESS (Street, city or town, state) Frederick, Md.		DATE SIGNED 9/19/58		
PHYSICIAN'S NAME (Type) Charles H. Conley Jr.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21-58		22c. NAME OF CEMETERY OR CREMATORY Reformed		22d. LOCATION (City, town, or county) (State) Knoxville, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Frost				ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE SEP 23 '58		
						24b. REGISTRAR'S SIGNATURE Christina L. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10607

10613

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 WKS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Rural 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Russell Last Bishop				4. DATE OF DEATH Month 9 Day 19 Year 58			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4.30.1915		9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months 4 Days 20	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Washington County Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Millard L Bishop				14. MOTHER'S MAIDEN NAME Annie B Manson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-03-8610		17. INFORMANT Mrs Jessie L Bishop Hancock Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PRIMARY CARCINOMA OF Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CIRRHOSIS OF Liver DUE TO (c) CHRONIC Alcoholism							INTERVAL BETWEEN ONSET AND DEATH 4 mos. ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 322:1							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month Day Year 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Aug. 30, 1958 , to Sept. 19, 1958 , that I last saw the deceased alive on Sept. 19, 1958 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 215 W. WASHINGTON ST. HAGERSTOWN, MD. DATE SIGNED 9/23/58							
ACTUAL SIGNATURE John A. Moran		M.D. 215 W. WASHINGTON ST. HAGERSTOWN, MD.					
PHYSICIAN'S NAME (Type) JOHN A. MORAN		HAGERSTOWN, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9.23.58	22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Hancock Washington Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Hancock J. Moore Hancock Md				24a. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

2002

LIST OF

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10614

CERTIFICATE OF DEATH

Reg. Dist. No. 302

10608

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>03</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>130 Mechanic Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PEARL</u> Middle <u>ADALINE</u> Last <u>BOIZ</u>		4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>1958</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22, 1884</u>		9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Williamsport, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rubin Rudolph Palmer</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-14-5043</u>		17. INFORMANT Address <u>Max Krumpke Funkstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, generalized</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Carcinoma of ovary</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>9 months.</u> <u>unknown - 18 months?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/18</u> , 19 <u>58</u> , to <u>9/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/5</u> , 19 <u>58</u> , and that death occurred at <u>9:45</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Jennings</u>				ADDRESS (Street, city or town, state) <u>136 W. Washington St. Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>George Jennings</u>				DATE SIGNED <u>9/6/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/8/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>K. Franklin Berger</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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Age 10618

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CERTIFICATE OF DEATH

Reg. Dist. No.

10609

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 12 YEARS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1019 SPRUCE STREET				d. STREET ADDRESS 1019 SPRUCE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CHARLES Middle EDWARD Last BOWMAN				4. DATE OF DEATH Month SEPTEMBER Day 8 Year 1958 19				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 28 1872		
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86		IF UNDER 24 HRS. Months 86 Days 86 Hours 86 Min. 86				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE PAINTER			10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) FUNKSTOWN WASH.CO.MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID BOWMAN				14. MOTHER'S MAIDEN NAME SUSAN ROWE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-30-9810		17. INFORMANT MRS. PERCY LINE 1019 spruce street HAGERSTOWN MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease (c) Hypertrophy of the Heart							INTERVAL BETWEEN ONSET AND DEATH 5 yrs 6 m	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7-1-58 , 19 58 , to 9-8-58 , that I last saw the deceased alive on 9-6-58 , 19 58 , and that death occurred at 9-8-58 M, from the causes and on the date stated above.								
ACTUAL SIGNATURE A. E. Outh				ADDRESS (Street, city or town, state) Hagerstown Md				
PHYSICIAN'S NAME (Type) DR E W J, Jr				DATE SIGNED 9/9/58				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 11 1958		22c. NAME OF CEMETERY OR CREMATORY FUNKSTOWN CEMETERY		22d. LOCATION (City, town, or county) (State) FUNKSTOWN WASH.CO.MD.		
23. FUNERAL DIRECTOR'S SIGNATURE John H. Post				ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR DATE SEP 15 '58		
				24b. REGISTRAR'S SIGNATURE Arthur L. Huns				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10676

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if no information Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural San Mar</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fahrney Keedy Memorial Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Grace</u> Last <u>Brechbill</u>		4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John G. Brechbill</u>		14. MOTHER'S MAIDEN NAME <u>Alice Kauffman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Richard Shuman, Marion, Pa</u>		Address <u>Marion, Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral haemorrhage</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 2, 1958</u> , to <u>Sept 1, 1958</u> , that I last saw the deceased alive on <u>Aug 31, 1958</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. Heelan</u>		DATE SIGNED <u>9/1/58</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Heelan</u>		ADDRESS (Street, city or town, state) <u>Brownstown - Ind.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/3/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle Indiana Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard M. Shuman</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 3 '58</u>	
ADDRESS <u>Greencastle, Pa</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10611

10616

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stanley Middle Russell Last Brill		4. DATE OF DEATH Month 9 Day 17 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1887
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber		10b. KIND OF BUSINESS OR INDUSTRY OWN shop	
11. BIRTHPLACE (State or foreign country) Wardensville, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Russell Brill		14. MOTHER'S MAIDEN NAME Martha Viands	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-30-9843	
17. INFORMANT Mrs. Jessie Brill		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction due 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive vascular disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 10, 1956 , to Sept 17, 1958 , that I last saw the deceased alive on Sept 17, 1958 , and that death occurred at 1:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. E. W. Ditto III MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 9-20-58	22c. NAME OF CEMETERY OR CREMATORY Rest Haven	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

1912

DATE OF DEATH

PLACE

NAME OF DECEASED

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No. 302

10617

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>527 Mayfair Ave.</u>				d. STREET ADDRESS <u>527 Mayfair Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>LIEVETTA</u>		First <u>ROSE</u>		Middle <u>BUSEY</u>		Last	
4. DATE OF DEATH		Month <u>September</u>		Day <u>27</u>		Year <u>19 58</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 28, 1918</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR <u>4</u> Months <u>29</u> Days		IF UNDER 24 HRS. <u>4</u> Hours <u>29</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Market</u>		11. BIRTHPLACE (State or foreign country) <u>Chambersburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Maurice I. Ernst</u>				14. MOTHER'S MAIDEN NAME <u>Leona Naugle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>David E. Busey</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal metastatic carcinoma</u> DUE TO (b) <u>Hypernephroma of left kidney</u> DUE TO (c) <u>Unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 20,</u> 19 <u>56</u> , to <u>Sept. 26,</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 26</u> 19 <u>58</u> , and that death occurred at <u>A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>148 N. Potomac St., Hagerstown, Md.</u> DATE SIGNED <u>9-27-58</u>							
ACTUAL SIGNATURE <u>S. Earl Young</u>		M.D. <u>148 N. Potomac St., Hagerstown, Md.</u>					
PHYSICIAN'S NAME (Type) <u>S. Earl Young, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 2 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

300

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of witness	
				</																			

10618

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Ruth Carbaugh</u>				4. DATE OF DEATH Month Day Year <u>Sept. 12 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 1, 1929</u>	
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dress</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>	
13. FATHER'S NAME <u>Clarence Hadley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Hamburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Richard Carbaugh Hag. Rt. 6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Hypertension</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>probable coronary occlusion</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>30 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Sept 6</u> , 19 <u>58</u> , to <u>Sept 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>58</u> , and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D. <u>217 W. Washington St.</u> PHYSICIAN'S NAME (Type) <u>Edward W. Ditto</u> <u>Hagerstown Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-14-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Minnich Funeral Home Hagerstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10677

CERTIFICATE OF DEATH

Reg. Dist. No.

10614

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILLIAMSPORT - RURAL c. LENGTH OF STAY IN 1b 6 1/2 MO d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOMewood Home For AGed			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TANEYTOWN d. STREET ADDRESS 06X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last EMMA MAY CLEM			4. DATE OF DEATH Month Day Year Sept 2 1958		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		8b. KIND OF BUSINESS OR INDUSTRY Own home		9. AGE (In years lost birthday) 84 yrs. IF UNDER 1 YEAR Months Days Hours Min. 2 1958	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Own home		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Elizabeth E. Austin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Alice Clem, Taneytown, Md.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 yrs					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 7-1-58 , 19____, to 9-2- , 19 58 , that I last saw the deceased alive on 8-28-58 , 19____, and that death occurred at 4:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE S. W. Seltz M.D. Arthur E. Hume PHYSICIAN'S NAME (Type) S. W. Seltz					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Haugh's Cemetery	
22d. LOCATION (City, town, or county) (State) New Midway, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss ADDRESS C. O. Fuss & Son, Taneytown, Maryland			24a. REC'D BY REGISTRAR DATE SEP 4 '58		
24b. REGISTRAR'S SIGNATURE Arthur E. Hume					

CERTIFICATE OF DEATH

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10678

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leitersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lewis Middle Edward Last Clopper		4. DATE OF DEATH Month Sept. Day 29 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1871
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Leitersburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry G. Clopper		14. MOTHER'S MAIDEN NAME Maggie Petre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --	
17. INFORMANT Williamsport Sanitarium, Williamsport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 422.1 DUE TO Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Stroke DUE TO (c) Arteriosclerotic cardiovascular disease 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 , 19 58 to Sept 29 , 19 58 that I last saw the deceased alive on Sept 28 , 19 58 , and that death occurred at 3:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE M Byrkit		M.D. 28 W. Potomac Williamsport, Md	
PHYSICIAN'S NAME (Type) Max E. Byrkit, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 10-1-58	22c. NAME OF CEMETERY OR CREMATORY Leitersburg Cemetery	22d. LOCATION (City, town, or county) (State) Leitersburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR OCT 9 58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10616

10619

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1100 block Jefferson St.,		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Washington Last Cressler Jr		4. DATE OF DEATH Month 9 Day 2 Year 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1894
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Breencastle, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Cressler Sr.		14. MOTHER'S MAIDEN NAME Julia Gearhart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W. I		16. SOCIAL SECURITY NO. 217-32-5265	
17. INFORMANT Mrs. Ida M. Cressler		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 Hr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-1 , 19 56 to 9-2 , 19 58 , that I last saw the deceased alive on 3-1 , 19 58 , and that death occurred at 12 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Charles F. Hess M.D. Smithsburg Md. 9-2-58 PHYSICIAN'S NAME (Type) Charles F. Hess M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-4-58	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE SEP 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

CERTIFICATE OF DEATH

1913

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF ATTENDING PHYSICIAN

NAME OF NURSE

NAME OF MIDWIFE

NAME OF DENTIST

NAME OF OPTICIAN

NAME OF PHARMACEUTICIAN

NAME OF VETERINARIAN

NAME OF JUDGE

NAME OF CLERK

NAME OF ASSISTANT

NAME OF ATTENDING PHYSICIAN

NAME OF NURSE

NAME OF MIDWIFE

NAME OF DENTIST

NAME OF OPTICIAN

NAME OF PHARMACEUTICIAN

NAME OF VETERINARIAN

10617

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Washington

Washington

Washington, D.C.

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10621

CERTIFICATE OF DEATH

Reg. Dist. No.

10618

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE PENNSYLVANIA COUNTY FRANKLIN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENCASTLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 129 N. ALLISON ST.	
3. NAME OF DECEASED (Type or print) First ELMER Middle D. Last DIETRICH		4. DATE OF DEATH Month SEPT. Day 22 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	9. AGE (In years last birthday) 75 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN DIETRICH		14. MOTHER'S MAIDEN NAME LYDIA DIETRICH <i>Wheeler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-20 846	
17. INFORMANT MRS. ROBERTA DIETRICH		Address GREENCASTLE PA.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHO SARcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Uncertain - ? 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-16, 19 58 , to 9-22, 19 58 , that I last saw the deceased alive on 9-22, 19 58 , and that death occurred at 4 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 154 West Washington St., Hagerstown, Md. DATE SIGNED 9:23:58			
ACTUAL SIGNATURE John H. Hornbaker M.D.		DATE SIGNED 9:23:58	
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/25/58	22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Winnich		24a. REC'D BY REGISTRAR DATE SEP 29 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10679

CERTIFICATE OF DEATH

10619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fredrick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>				c. LENGTH OF STAY IN 1b <u>2 yrs. 7 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeders Nursing Home</u>				d. STREET ADDRESS <u>Walkersville 10X-2</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First Middle Last <u>CARL DODSON</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 8, 1891</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miller</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Flour mill</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles M. Dodson</u>				14. MOTHER'S MAIDEN NAME <u>Nannie Andrews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-01-5618</u>		17. INFORMANT <u>Mrs. Lena M. Dodson</u> Address <u>Balto., Md. 2303 W. Laurel St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac collapse</u> <u>053.1</u> DUE TO <u>Staphylococcal - Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Parkinsonism</u> (c) <u>Parkinsonism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Min</u> <u>day</u> <u>hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>9/11</u> , 19 <u>58</u> , to <u>9/16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis G. Graft</u> M.D.				ADDRESS (Street, city or town, state) <u>119 S. Antietam St.</u> DATE SIGNED <u>9/12/58</u>			
PHYSICIAN'S NAME (Type) <u>Louis G. Graft</u>				Hegentam, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 18, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Piney Grove cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Airy Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. E. Barton</u>				ADDRESS <u>Walkersville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 19 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

1

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, ON JANUARY 15, 1950.

210-2014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10621

10623

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md				c. LENGTH OF STAY IN 1b 3 Wks.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Charles Middle Lewis Last Dunham				4. DATE OF DEATH Month 9 Day 26 Year 19 58			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.10.1884		9. AGE (In years and birthday) yrs. 74	IF UNDER 1 YEAR Months 3 Days 26	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Duncan W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Dunham				14. MOTHER'S MAIDEN NAME Mary Schuteeworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 301-22-6735		17. INFORMANT Address George A Dunham Sandyville W.VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, BASILAR 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUGUST 22 , 19 58 , to SEPTEMBER 26 , 19 58 , that I last saw the deceased alive on SEPTEMBER 26 , 19 58 , and that death occurred at 2-40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Archie Robert Cohen M.D.				PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D. CLEAR SPRING, MARYLAND 9-26-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9.28.58		22c. NAME OF CEMETERY OR CREMATORY Ravenwood Cemetery		22d. LOCATION (City, town, or county) (State) Revenwood Jackson W.VA.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Howard F. Lane Hancocks Md				24a. REC'D BY REGISTRAR DATE SEP 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10624

CERTIFICATE OF DEATH

10622

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 35 Min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jack Ecobona		4. DATE OF DEATH Month Day Year 9 1 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1888
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) crane operator		10b. KIND OF BUSINESS OR INDUSTRY W.M. R.R.	
11. BIRTHPLACE (State or foreign country) Florence, Italy		12. CITIZEN OF WHAT COUNTRY? ITALY	
13. FATHER'S NAME George Ecobona		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Earl Ecobona		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-1-58 , 19 58 , to 9-1-58 , 19 58 , that I last saw the deceased alive on 8-24-58 , 19 58 , and that death occurred at 11:30 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. W. Ditt M.D. Hagerstown Md PHYSICIAN'S NAME (Type) Dr E W Ditt Hagerstown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-4-58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE SEP 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraiss	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u>				c. LENGTH OF STAY IN 1b <u>40 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>28 S. Main St.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>H.</u> Last <u>Eshleman</u>				4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 31, 1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>general store</u>		11. BIRTHPLACE (State or foreign country) <u>Ranson, Kansas</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Daniel Eshleman</u>				14. MOTHER'S MAIDEN NAME <u>(last name) Horst</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>219-07-8695</u>		17. INFORMANT <u>Cora M. Eshleman, Smithsburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure (hepatic coma)</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Cirrhosis of liver</u> DUE TO (c) <u>Valvular (hematic) heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>months</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u> <u>IXXXXXX</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1958</u> Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Smithsburg</u>				20g. (County) <u>Washington</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>9/21</u> , 19 <u>58</u> , to <u>9/21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/21/58</u> , 19 <u>58</u> , and that death occurred at <u>9:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>145 S. Prospect Street</u> DATE SIGNED <u>John C. Stauffer</u> ACTUAL SIGNATURE <u>John C. Stauffer</u> M.D. <u>145 S. Prospect Street</u> PHYSICIAN'S NAME (Type) <u>John C. Stauffer, M.D.</u> <u>Hagerstown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9-23-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Smithsburg, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10681

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		c. LENGTH OF STAY IN 1b 63 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Maryland.	
f. STREET ADDRESS 42 East Main		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Josephine Middle Everts Last Everts		4. DATE OF DEATH Month 9 Day 29 Year 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4.25.1876
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 5 Days 4	11. IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Crab Orchard K.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Issac Gramham		14. MOTHER'S MAIDEN NAME Mary Sharp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harry E Everts Hancock Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-15 , 19 58 to 9-29 , 19 58 , that I last saw the deceased alive on 9-15 , 19 58 , and that death occurred at 12:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Buckley Springs, W. Va DATE SIGNED 10-1-58			
ACTUAL SIGNATURE Herbert R. Tobias		PHYSICIAN'S NAME (Type) Herbert R. Tobias	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10.2.58	
22c. NAME OF CEMETERY OR CREMATORIUM Rehobeth Methodist		22d. LOCATION (City, town, or county) (State) Fulton County Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard F. Jones		24a. REC'D BY REGISTRAR DATE OCT. 6 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10625

CERTIFICATE OF DEATH

10625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 51 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 20 EAST AVE.		d. STREET ADDRESS 20 EAST AVE.	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle WILLIAM Last FLEMING		4. DATE OF DEATH Month SEPT. Day 7 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/1881
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BARBER		10b. KIND OF BUSINESS OR INDUSTRY OWN SHOP	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MOSES K. FLEMING		14. MOTHER'S MAIDEN NAME DERACY ELIZABETH KIMBLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-3894	
17. INFORMANT MR. MORRIS FLEMING		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Arterio Sclerotic Heart Disease with Myocardial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 , 19____, to 7 Sept , 19 58 , that I last saw the deceased alive on 7 Sept , 19 58 , and that death occurred at 11P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 230 W Potomac Hagerstown Md. DATE SIGNED 9/4/58 ACTUAL SIGNATURE F.F. Lusby PHYSICIAN'S NAME (Type) F.F. Lusby			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/10/58	
22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W.J. Norment		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
24b. REGISTRAR'S SIGNATURE Charles L. Frank			

CERTIFICATE OF DEATH

10023

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES M. JONES		JAN 15 1968		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
45		M		W	
MARRIED		OCCUPATION		EDUCATION	
MARRIED		LABORER		HIGH SCHOOL	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
JAN 15 1923		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT	
HEART DISEASE		NATURAL		BALTIMORE, MARYLAND	
DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
JAN 18 1968		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE	
JAMES M. JONES		JAMES M. JONES		BALTIMORE, MARYLAND	
DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAN 15 1968		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

10626

CERTIFICATE OF DEATH

10626

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH.CO.HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROWNSVILLE d. STREET ADDRESS 314 N. Potomac St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LINDA K FRAVEL		4. DATE OF DEATH Month Day Year SEPTEMBER 20 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 17 1952
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) HAGERSTOWN WASH.CO.MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES R.FRAVEL		14. MOTHER'S MAIDEN NAME DOROTHY MILLS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JAMES R.FRAVEL BROWNSVILLE WASH.CO.MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain Abscess DUE TO (c) Otitis Media INTERVAL BETWEEN ONSET AND DEATH 12 hours 12 days 17 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-18 , 19 58 , to 9-20 , 19 58 , that I last saw the deceased alive on 9-20 , 19 58 , and that death occurred at 8:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. Margaret Sullivan M.D.		ADDRESS (Street, city or town, state) 314 N. Potomac St. Hagerstown, Maryland	
DATE SIGNED 9-22-58			
PHYSICIAN'S NAME (Type) E. Margaret Sullivan M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 23 1958	22c. NAME OF CEMETERY OR CREMATORY BROWNSVILLE HEIGHTS CEMETERY BROWNSVILLE MD.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE John H. East		ADDRESS Boonsboro Md.	
24a. REC'D BY REGISTRAR DATE SEP 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
AGE		DATE OF BIRTH	
35		JANUARY 5, 1933	
SEX		RACE	
MALE		WHITE	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
OCCUPATION		PLACE OF BIRTH	
ATTORNEY		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		SUICIDE	
DETAILS OF CAUSE OF DEATH		DETAILS OF MANNER OF DEATH	
CORONER'S OFFICE		PLACE OF DEATH	
BALTIMORE		MEMPHIS, TENNESSEE	
DATE OF INTERVIEW		DATE OF DEATH	
APRIL 4, 1968		APRIL 4, 1968	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968	
NAME OF HOSPITAL		NAME OF CITY	
[Name]		MEMPHIS	
NAME OF COUNTY		NAME OF STATE	
BALTIMORE		TENNESSEE	
NAME OF DISTRICT		NAME OF COUNTRY	
[Name]		UNITED STATES OF AMERICA	
NAME OF DECEASED		NAME OF NEXT OF KIN	
JAMES EARL RAY		[Name]	
ADDRESS OF DECEASED		ADDRESS OF NEXT OF KIN	
[Address]		[Address]	
CITY OF DECEASED		CITY OF NEXT OF KIN	
BALTIMORE		[City]	
STATE OF DECEASED		STATE OF NEXT OF KIN	
MARYLAND		[State]	
COUNTRY OF DECEASED		COUNTRY OF NEXT OF KIN	
UNITED STATES OF AMERICA		UNITED STATES OF AMERICA	
NAME OF DECEASED		NAME OF NEXT OF KIN	
JAMES EARL RAY		[Name]	
ADDRESS OF DECEASED		ADDRESS OF NEXT OF KIN	
[Address]		[Address]	
CITY OF DECEASED		CITY OF NEXT OF KIN	
BALTIMORE		[City]	
STATE OF DECEASED		STATE OF NEXT OF KIN	
MARYLAND		[State]	
COUNTRY OF DECEASED		COUNTRY OF NEXT OF KIN	
UNITED STATES OF AMERICA		UNITED STATES OF AMERICA	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10627

10627

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W. sh. county Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>MAUGANS</u> Last <u>GARVIN</u>		4. DATE OF DEATH Month <u>September</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Edgemont Wash Co Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>David M. Maugans</u>	
14. MOTHER'S MAIDEN NAME <u>Susan Forrest</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ammon S. Garvin 706 Summit Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac standstill</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Complete heart block</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few months</u> <u>1 yr +</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>481 Grippe</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 Dec 1957</u> , to <u>20 Sept 1958</u> , that I last saw the deceased alive on <u>20 Sept 1958</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D.		22. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. TIME OF DEATH [Faint text]</p>	
<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>14. DATE OF DEATH [Faint text]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10628

CERTIFICATE OF DEATH

Reg. Dist. No.

10628

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS W. Water St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grover Middle Cleveland Last Gaver				4. DATE OF DEATH Month Sept. Day 16, Year 19 58			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 16, 1892	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter				10b. KIND OF BUSINESS OR INDUSTRY house contractor		11. BIRTHPLACE (State or foreign country) Highland, Fred.Co., Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Phillip Gaver				14. MOTHER'S MAIDEN NAME Anna E. Hooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-16-0202		17. INFORMANT Mary E. Gaver, Smithsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericarditis Hemorrhage DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior Sclerosis DUE TO 10 yrs (c) 16 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs INTERVAL BETWEEN ONSET AND DEATH 16 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Aug 31, 1958 to Sept 16, 1958 that I last saw the deceased alive on Sept 16, 1958 , and that death occurred at 2:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 9/17/58 ACTUAL SIGNATURE G. A. Kohler M.D. PHYSICIAN'S NAME (Type) G. A. KOHLER M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-19-58		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				24a. REC'D BY REGISTRAR DATE SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		DATE OF DEATH JAN 10 1900	
PLACE OF DEATH BALTIMORE, MARYLAND		AGE 45	
OCCUPATION Carpenter		SEX Male	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF BURIAL JAN 12 1900		PLACE OF BURIAL St. Paul's Church	
NAME OF FUNERAL HOME J. J. Harris		NAME OF MINISTER Rev. J. J. Harris	
NAME OF NEXT OF KIN J. J. Harris		NAME OF PHYSICIAN Dr. J. J. Harris	
NAME OF CORONER J. J. Harris		NAME OF JURY J. J. Harris	
NAME OF WITNESSES J. J. Harris		NAME OF REGISTRAR J. J. Harris	
NAME OF CLERK J. J. Harris		NAME OF ASSISTANT CLERK J. J. Harris	
NAME OF DECEASED'S MOTHER J. J. Harris		NAME OF DECEASED'S FATHER J. J. Harris	
NAME OF DECEASED'S BROTHER J. J. Harris		NAME OF DECEASED'S SISTER J. J. Harris	
NAME OF DECEASED'S WIFE J. J. Harris		NAME OF DECEASED'S CHILDREN J. J. Harris	
NAME OF DECEASED'S GRANDPARENTS J. J. Harris		NAME OF DECEASED'S UNCLE J. J. Harris	
NAME OF DECEASED'S AUNT J. J. Harris		NAME OF DECEASED'S NEPHEW J. J. Harris	
NAME OF DECEASED'S NIECE J. J. Harris		NAME OF DECEASED'S COUSIN J. J. Harris	
NAME OF DECEASED'S FIRST COUSIN J. J. Harris		NAME OF DECEASED'S SECOND COUSIN J. J. Harris	
NAME OF DECEASED'S THIRD COUSIN J. J. Harris		NAME OF DECEASED'S FOURTH COUSIN J. J. Harris	
NAME OF DECEASED'S FIFTH COUSIN J. J. Harris		NAME OF DECEASED'S SIXTH COUSIN J. J. Harris	
NAME OF DECEASED'S SEVENTH COUSIN J. J. Harris		NAME OF DECEASED'S EIGHTH COUSIN J. J. Harris	
NAME OF DECEASED'S NINTH COUSIN J. J. Harris		NAME OF DECEASED'S TENTH COUSIN J. J. Harris	
NAME OF DECEASED'S ELEVENTH COUSIN J. J. Harris		NAME OF DECEASED'S TWELFTH COUSIN J. J. Harris	
NAME OF DECEASED'S THIRTEENTH COUSIN J. J. Harris		NAME OF DECEASED'S FOURTEENTH COUSIN J. J. Harris	
NAME OF DECEASED'S FIFTEENTH COUSIN J. J. Harris		NAME OF DECEASED'S SIXTEENTH COUSIN J. J. Harris	
NAME OF DECEASED'S SEVENTEENTH COUSIN J. J. Harris		NAME OF DECEASED'S EIGHTEENTH COUSIN J. J. Harris	
NAME OF DECEASED'S NINETEENTH COUSIN J. J. Harris		NAME OF DECEASED'S TWENTIETH COUSIN J. J. Harris	
NAME OF DECEASED'S TWENTY-FIRST COUSIN J. J. Harris		NAME OF DECEASED'S TWENTY-SECOND COUSIN J. J. Harris	
NAME OF DECEASED'S TWENTY-THIRD COUSIN J. J. Harris		NAME OF DECEASED'S TWENTY-FOURTH COUSIN J. J. Harris	
NAME OF DECEASED'S TWENTY-FIFTH COUSIN J. J. Harris		NAME OF DECEASED'S TWENTY-SIXTH COUSIN J. J. Harris	
NAME OF DECEASED'S TWENTY-SEVENTH COUSIN J. J. Harris		NAME OF DECEASED'S TWENTY-EIGHTH COUSIN J. J. Harris	
NAME OF DECEASED'S TWENTY-NINTH COUSIN J. J. Harris		NAME OF DECEASED'S THIRTIETH COUSIN J. J. Harris	
NAME OF DECEASED'S THIRTY-FIRST COUSIN J. J. Harris		NAME OF DECEASED'S THIRTY-SECOND COUSIN J. J. Harris	
NAME OF DECEASED'S THIRTY-THIRD COUSIN J. J. Harris		NAME OF DECEASED'S THIRTY-FOURTH COUSIN J. J. Harris	
NAME OF DECEASED'S THIRTY-FIFTH COUSIN J. J. Harris		NAME OF DECEASED'S THIRTY-SIXTH COUSIN J. J. Harris	
NAME OF DECEASED'S THIRTY-SEVENTH COUSIN J. J. Harris		NAME OF DECEASED'S THIRTY-EIGHTH COUSIN J. J. Harris	
NAME OF DECEASED'S THIRTY-NINTH COUSIN J. J. Harris		NAME OF DECEASED'S FORTIETH COUSIN J. J. Harris	
NAME OF DECEASED'S FORTY-FIRST COUSIN J. J. Harris		NAME OF DECEASED'S FORTY-SECOND COUSIN J. J. Harris	
NAME OF DECEASED'S FORTY-THIRD COUSIN J. J. Harris		NAME OF DECEASED'S FORTY-FOURTH COUSIN J. J. Harris	
NAME OF DECEASED'S FORTY-FIFTH COUSIN J. J. Harris		NAME OF DECEASED'S FORTY-SIXTH COUSIN J. J. Harris	
NAME OF DECEASED'S FORTY-SEVENTH COUSIN J. J. Harris		NAME OF DECEASED'S FORTY-EIGHTH COUSIN J. J. Harris	
NAME OF DECEASED'S FORTY-NINTH COUSIN J. J. Harris		NAME OF DECEASED'S FIFTIETH COUSIN J. J. Harris	
NAME OF DECEASED'S FIFTY-FIRST COUSIN J. J. Harris		NAME OF DECEASED'S FIFTY-SECOND COUSIN J. J. Harris	
NAME OF DECEASED'S FIFTY-THIRD COUSIN J. J. Harris		NAME OF DECEASED'S FIFTY-FOURTH COUSIN J. J. Harris	
NAME OF DECEASED'S FIFTY-FIFTH COUSIN J. J. Harris		NAME OF DECEASED'S FIFTY-SIXTH COUSIN J. J. Harris	
NAME OF DECEASED'S FIFTY-SEVENTH COUSIN J. J. Harris		NAME OF DECEASED'S FIFTY-EIGHTH COUSIN J. J. Harris	
NAME OF DECEASED'S FIFTY-NINTH COUSIN J. J. Harris		NAME OF DECEASED'S SIXTIETH COUSIN J. J. Harris	
NAME OF DECEASED'S SIXTY-FIRST COUSIN J. J. Harris		NAME OF DECEASED'S SIXTY-SECOND COUSIN J. J. Harris	
NAME OF DECEASED'S SIXTY-THIRD COUSIN J. J. Harris		NAME OF DECEASED'S SIXTY-FOURTH COUSIN J. J. Harris	
NAME OF DECEASED'S SIXTY-FIFTH COUSIN J. J. Harris		NAME OF DECEASED'S SIXTY-SIXTH COUSIN J. J. Harris	
NAME OF DECEASED'S SIXTY-SEVENTH COUSIN J. J. Harris		NAME OF DECEASED'S SIXTY-EIGHTH COUSIN J. J. Harris	
NAME OF DECEASED'S SIXTY-NINTH COUSIN J. J. Harris		NAME OF DECEASED'S SIXTY-THIRD COUSIN J. J. Harris	
NAME OF DECEASED'S SIXTY-FOURTH COUSIN J. J. Harris		NAME OF DECEASED'S SIXTY-FIFTH COUSIN J. J. Harris	
NAME OF DECEASED'S SIXTY-FIFTH COUSIN J. J. Harris		NAME OF DECEASED'S SIXTY-SIXTH COUSIN J. J. Harris	
NAME OF DECEASED'S SIXTY-SIXTH COUSIN J. J. Harris		NAME OF DECEASED'S SIXTY-SEVENTH COUSIN J. J. Harris	
NAME OF DECEASED'S SIXTY-EIGHTH COUSIN J. J. Harris		NAME OF DECEASED'S SIXTY-EIGHTH COUSIN J. J. Harris	
NAME OF DECEASED'S SIXTY-NINTH COUSIN J. J. Harris		NAME OF DECEASED'S SIXTY-NINTH COUSIN J. J. Harris	
NAME OF DECEASED'S SEVENTIETH COUSIN J. J. Harris		NAME OF DECEASED'S SEVENTIETH COUSIN J. J. Harris	
NAME OF DECEASED'S SEVENTY-FIRST COUSIN J. J. Harris		NAME OF DECEASED'S SEVENTY-SECOND COUSIN J. J. Harris	
NAME OF DECEASED'S SEVENTY-THIRD COUSIN J. J. Harris		NAME OF DECEASED'S SEVENTY-FOURTH COUSIN J. J. Harris	
NAME OF DECEASED'S SEVENTY-FIFTH COUSIN J. J. Harris		NAME OF DECEASED'S SEVENTY-SIXTH COUSIN J. J. Harris	
NAME OF DECEASED'S SEVENTY-SEVENTH COUSIN J. J. Harris		NAME OF DECEASED'S SEVENTY-EIGHTH COUSIN J. J. Harris	
NAME OF DECEASED'S SEVENTY-NINTH COUSIN J. J. Harris		NAME OF DECEASED'S EIGHTIETH COUSIN J. J. Harris	
NAME OF DECEASED'S EIGHTY-FIRST COUSIN J. J. Harris		NAME OF DECEASED'S EIGHTY-SECOND COUSIN J. J. Harris	
NAME OF DECEASED'S EIGHTY-THIRD COUSIN J. J. Harris		NAME OF DECEASED'S EIGHTY-FOURTH COUSIN J. J. Harris	
NAME OF DECEASED'S EIGHTY-FIFTH COUSIN J. J. Harris		NAME OF DECEASED'S EIGHTY-SIXTH COUSIN J. J. Harris	
NAME OF DECEASED'S EIGHTY-SEVENTH COUSIN J. J. Harris		NAME OF DECEASED'S EIGHTY-EIGHTH COUSIN J. J. Harris	
NAME OF DECEASED'S EIGHTY-NINTH COUSIN J. J. Harris		NAME OF DECEASED'S NINETY COUSIN J. J. Harris	
NAME OF DECEASED'S NINETY-FIRST COUSIN J. J. Harris		NAME OF DECEASED'S NINETY-SECOND COUSIN J. J. Harris	
NAME OF DECEASED'S NINETY-THIRD COUSIN J. J. Harris		NAME OF DECEASED'S NINETY-FOURTH COUSIN J. J. Harris	
NAME OF DECEASED'S NINETY-FIFTH COUSIN J. J. Harris		NAME OF DECEASED'S NINETY-SIXTH COUSIN J. J. Harris	
NAME OF DECEASED'S NINETY-SEVENTH COUSIN J. J. Harris		NAME OF DECEASED'S NINETY-EIGHTH COUSIN J. J. Harris	
NAME OF DECEASED'S NINETY-NINTH COUSIN J. J. Harris		NAME OF DECEASED'S HUNDRED COUSIN J. J. Harris	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10629

Reg. Disl. No.

10682

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown c. LENGTH OF STAY IN 1b 6 mi east Funkstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown	
3. NAME OF DECEASED (Type or print) Phillip Randolph Godlove		4. DATE OF DEATH September 22 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1934
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Fiddlersburg Md.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME William W. Godlove		14. MOTHER'S MAIDEN NAME Katherine Knight	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT Mrs. William W. Godlove		Address Route 5	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Open fractured skull 816X DUE TO Multiple fractured ribs Conditions, if any, which gave rise to immediate cause (b) Hemorrhage and shock (c) Hemorrhage and shock gave rise to the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was operator of auto that was involved in a collision with another car	
20c. TIME OF INJURY Month, Day, Year 12-55 9-21- 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Rural Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-58	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>4 Hrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>124 So Potomac St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HATTIE BELL GROVES</u>		4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15 1878</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>6</u> Hours <u>3</u> Min. <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rooming house operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rooming house operator</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ewell Rose</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Jane Groves</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Miss Naomi Rose</u>		Address <u>124 So Potomac St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> (c) <u>Diabetes mellitus</u> DUE TO <u>arteriosclerosis</u> <u>General</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>6 yrs.</u> <u>3 yrs.</u> <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>240X</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 2</u> , 19 <u>58</u> , to <u>Sept 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 27</u> , 19 <u>58</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>159 W. Washington St. Hagerstown, Md.</u> DATE SIGNED <u>9/29/58</u>			
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		M.D. <u>159 W. Washington St. Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/30/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10-1

1. NAME OF DECEASED JOHN J. ROY		2. SEX MALE		3. AGE 68	
4. DATE OF DEATH APR 15 1968		5. TIME OF DEATH 10:15 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN DR. J. H. ROY	
10. SIGNATURE OF REGISTRAR JOHN J. ROY		11. SIGNATURE OF WITNESSES JOHN J. ROY		12. SIGNATURE OF DECEASED JOHN J. ROY	
13. SIGNATURE OF DECEASED JOHN J. ROY		14. SIGNATURE OF DECEASED JOHN J. ROY		15. SIGNATURE OF DECEASED JOHN J. ROY	
16. SIGNATURE OF DECEASED JOHN J. ROY		17. SIGNATURE OF DECEASED JOHN J. ROY		18. SIGNATURE OF DECEASED JOHN J. ROY	
19. SIGNATURE OF DECEASED JOHN J. ROY		20. SIGNATURE OF DECEASED JOHN J. ROY		21. SIGNATURE OF DECEASED JOHN J. ROY	
22. SIGNATURE OF DECEASED JOHN J. ROY		23. SIGNATURE OF DECEASED JOHN J. ROY		24. SIGNATURE OF DECEASED JOHN J. ROY	
25. SIGNATURE OF DECEASED JOHN J. ROY		26. SIGNATURE OF DECEASED JOHN J. ROY		27. SIGNATURE OF DECEASED JOHN J. ROY	
28. SIGNATURE OF DECEASED JOHN J. ROY		29. SIGNATURE OF DECEASED JOHN J. ROY		30. SIGNATURE OF DECEASED JOHN J. ROY	
31. SIGNATURE OF DECEASED JOHN J. ROY		32. SIGNATURE OF DECEASED JOHN J. ROY		33. SIGNATURE OF DECEASED JOHN J. ROY	
34. SIGNATURE OF DECEASED JOHN J. ROY		35. SIGNATURE OF DECEASED JOHN J. ROY		36. SIGNATURE OF DECEASED JOHN J. ROY	
37. SIGNATURE OF DECEASED JOHN J. ROY		38. SIGNATURE OF DECEASED JOHN J. ROY		39. SIGNATURE OF DECEASED JOHN J. ROY	
40. SIGNATURE OF DECEASED JOHN J. ROY		41. SIGNATURE OF DECEASED JOHN J. ROY		42. SIGNATURE OF DECEASED JOHN J. ROY	
43. SIGNATURE OF DECEASED JOHN J. ROY		44. SIGNATURE OF DECEASED JOHN J. ROY		45. SIGNATURE OF DECEASED JOHN J. ROY	
46. SIGNATURE OF DECEASED JOHN J. ROY		47. SIGNATURE OF DECEASED JOHN J. ROY		48. SIGNATURE OF DECEASED JOHN J. ROY	
49. SIGNATURE OF DECEASED JOHN J. ROY		50. SIGNATURE OF DECEASED JOHN J. ROY		51. SIGNATURE OF DECEASED JOHN J. ROY	
52. SIGNATURE OF DECEASED JOHN J. ROY		53. SIGNATURE OF DECEASED JOHN J. ROY		54. SIGNATURE OF DECEASED JOHN J. ROY	
55. SIGNATURE OF DECEASED JOHN J. ROY		56. SIGNATURE OF DECEASED JOHN J. ROY		57. SIGNATURE OF DECEASED JOHN J. ROY	
58. SIGNATURE OF DECEASED JOHN J. ROY		59. SIGNATURE OF DECEASED JOHN J. ROY		60. SIGNATURE OF DECEASED JOHN J. ROY	
61. SIGNATURE OF DECEASED JOHN J. ROY		62. SIGNATURE OF DECEASED JOHN J. ROY		63. SIGNATURE OF DECEASED JOHN J. ROY	
64. SIGNATURE OF DECEASED JOHN J. ROY		65. SIGNATURE OF DECEASED JOHN J. ROY		66. SIGNATURE OF DECEASED JOHN J. ROY	
67. SIGNATURE OF DECEASED JOHN J. ROY		68. SIGNATURE OF DECEASED JOHN J. ROY		69. SIGNATURE OF DECEASED JOHN J. ROY	
70. SIGNATURE OF DECEASED JOHN J. ROY		71. SIGNATURE OF DECEASED JOHN J. ROY		72. SIGNATURE OF DECEASED JOHN J. ROY	
73. SIGNATURE OF DECEASED JOHN J. ROY		74. SIGNATURE OF DECEASED JOHN J. ROY		75. SIGNATURE OF DECEASED JOHN J. ROY	
76. SIGNATURE OF DECEASED JOHN J. ROY		77. SIGNATURE OF DECEASED JOHN J. ROY		78. SIGNATURE OF DECEASED JOHN J. ROY	
79. SIGNATURE OF DECEASED JOHN J. ROY		80. SIGNATURE OF DECEASED JOHN J. ROY		81. SIGNATURE OF DECEASED JOHN J. ROY	
82. SIGNATURE OF DECEASED JOHN J. ROY		83. SIGNATURE OF DECEASED JOHN J. ROY		84. SIGNATURE OF DECEASED JOHN J. ROY	
85. SIGNATURE OF DECEASED JOHN J. ROY		86. SIGNATURE OF DECEASED JOHN J. ROY		87. SIGNATURE OF DECEASED JOHN J. ROY	
88. SIGNATURE OF DECEASED JOHN J. ROY		89. SIGNATURE OF DECEASED JOHN J. ROY		90. SIGNATURE OF DECEASED JOHN J. ROY	
91. SIGNATURE OF DECEASED JOHN J. ROY		92. SIGNATURE OF DECEASED JOHN J. ROY		93. SIGNATURE OF DECEASED JOHN J. ROY	
94. SIGNATURE OF DECEASED JOHN J. ROY		95. SIGNATURE OF DECEASED JOHN J. ROY		96. SIGNATURE OF DECEASED JOHN J. ROY	
97. SIGNATURE OF DECEASED JOHN J. ROY		98. SIGNATURE OF DECEASED JOHN J. ROY		99. SIGNATURE OF DECEASED JOHN J. ROY	
100. SIGNATURE OF DECEASED JOHN J. ROY		101. SIGNATURE OF DECEASED JOHN J. ROY		102. SIGNATURE OF DECEASED JOHN J. ROY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10631

10683

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u> c. LENGTH OF STAY IN 1b <u>minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 11 Middleburg Pike</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Greencastle</u> 75 x 3 ✓ d. STREET ADDRESS <u>Route #3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Edward</u> Last <u>Harrison</u>				4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>1958</u>													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 24, 1928</u>		9. AGE (In years last birthday) <u>30</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building House Trailers</u>				11. BIRTHPLACE (State or foreign country) <u>Franklin Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles E. Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Ida Belle Helman</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>World War II</u>				16. SOCIAL SECURITY NO. <u>174-20-8906</u>		17. INFORMANT <u>Im. Bruce Yeager, Greencastle, Pa</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>816X</u> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) <u>FRAC TURE SKULL</u></p> <p>DUE TO</p> <p>(c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>instant</u></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Crushed in his car that was struck by truck</u>													
20c. TIME OF INJURY Month, Day, Year <u>11/4/58</u> <u>9-7</u> <u>AM</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Rt. 11 Hagerstown Washington Md</u>		20f. (City or town) (County) (State) <u>Greencastle Franklin Pa</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquir <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>9/10/58</u>									
EXAMINER'S NAME (Type) <u>J. E. W. H. T. T. J.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 9/10/58 West Haven Cemetery</u>				22b. DATE THEREOF <u>9/10/58</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Hagerstown Wash Co Md</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Pa</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald H. Zimmerman, Greencastle, Pa</u>				ADDRESS <u>Greencastle, Pa</u>		24a. REC'D BY REGISTRAR <u>SEP 10 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FRANCIS J. O'NEILL

Completed for use that is subject of death
Date 8-2-20

Dr. R. L. Little
The F. H. Little Co.

10630

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>21 Elizabeth st</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>RALPH VICTOR HARNE</u>				4. DATE OF DEATH Month Day Year <u>September 4 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16 1891</u>		9. AGE (In years lost birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Central Chem Co</u>		11. BIRTHPLACE (State or foreign country) <u>Funkstown Wash. Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alvey Harne</u>				14. MOTHER'S MAIDEN NAME <u>Sally Gower</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-9811</u>		17. INFORMANT Address <u>Calvin Harne Jr 21 Elizabeth St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Acute congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>years</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>15</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>4 Sept. 1958</u>				20g. (County) <u>Washington</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>1 Sept.</u> , 19 <u>58</u> , to <u>4 Sept. 1958</u> , that I last saw the deceased alive on <u>4 Sept. 1958</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND</u> DATE SIGNED <u>9/5/58</u>							
ACTUAL SIGNATURE <u>J. D. Wilson</u>				M.D. <u>135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>J. D. WILSON, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Funkstown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Funkstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10684

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BIG SPRING		c. LENGTH OF STAY IN TB 22 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BIG SPRING ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle PAUL Last HART		4. DATE OF DEATH Month 9 Day 5 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 23, 1904
9. AGE (In years last birthday) yrs. 54		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRACKMAN		10b. KIND OF BUSINESS OR INDUSTRY W.M. RAILROAD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR HART		14. MOTHER'S MAIDEN NAME MARY BEARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. EDITH HART		Address BIG SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Unknown DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 5 , 19 58 , to Sept 5 , 19 58 , that I last saw the deceased alive on Sept 5 , 19 58 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David P. Brewer M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Clear Spring Md 9/6/58	
PHYSICIAN'S NAME (Type) David P. Brewer			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/8/58	
22c. NAME OF CEMETERY OR CREMATORY ST. PAULS		22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark ADDRESS CLEAR SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

And Burial

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u> years</p>	
<p>4. Date of death: <u>Jan 15, 1920</u></p>	
<p>5. Place of death: <u>Home</u></p>	
<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Signature of physician: <u>[Signature]</u></p>	
<p>8. Signature of registrar: <u>[Signature]</u></p>	
<p>9. Signature of undertaker: <u>[Signature]</u></p>	
<p>10. Signature of family: <u>[Signature]</u></p>	
<p>11. Signature of clergyman: <u>[Signature]</u></p>	
<p>12. Signature of coroner: <u>[Signature]</u></p>	
<p>13. Signature of health officer: <u>[Signature]</u></p>	
<p>14. Signature of registrar: <u>[Signature]</u></p>	
<p>15. Signature of undertaker: <u>[Signature]</u></p>	
<p>16. Signature of family: <u>[Signature]</u></p>	
<p>17. Signature of clergyman: <u>[Signature]</u></p>	
<p>18. Signature of coroner: <u>[Signature]</u></p>	
<p>19. Signature of health officer: <u>[Signature]</u></p>	
<p>20. Signature of registrar: <u>[Signature]</u></p>	
<p>21. Signature of undertaker: <u>[Signature]</u></p>	
<p>22. Signature of family: <u>[Signature]</u></p>	
<p>23. Signature of clergyman: <u>[Signature]</u></p>	
<p>24. Signature of coroner: <u>[Signature]</u></p>	
<p>25. Signature of health officer: <u>[Signature]</u></p>	
<p>26. Signature of registrar: <u>[Signature]</u></p>	
<p>27. Signature of undertaker: <u>[Signature]</u></p>	
<p>28. Signature of family: <u>[Signature]</u></p>	
<p>29. Signature of clergyman: <u>[Signature]</u></p>	
<p>30. Signature of coroner: <u>[Signature]</u></p>	
<p>31. Signature of health officer: <u>[Signature]</u></p>	
<p>32. Signature of registrar: <u>[Signature]</u></p>	
<p>33. Signature of undertaker: <u>[Signature]</u></p>	
<p>34. Signature of family: <u>[Signature]</u></p>	
<p>35. Signature of clergyman: <u>[Signature]</u></p>	
<p>36. Signature of coroner: <u>[Signature]</u></p>	
<p>37. Signature of health officer: <u>[Signature]</u></p>	
<p>38. Signature of registrar: <u>[Signature]</u></p>	
<p>39. Signature of undertaker: <u>[Signature]</u></p>	
<p>40. Signature of family: <u>[Signature]</u></p>	
<p>41. Signature of clergyman: <u>[Signature]</u></p>	
<p>42. Signature of coroner: <u>[Signature]</u></p>	
<p>43. Signature of health officer: <u>[Signature]</u></p>	
<p>44. Signature of registrar: <u>[Signature]</u></p>	
<p>45. Signature of undertaker: <u>[Signature]</u></p>	
<p>46. Signature of family: <u>[Signature]</u></p>	
<p>47. Signature of clergyman: <u>[Signature]</u></p>	
<p>48. Signature of coroner: <u>[Signature]</u></p>	
<p>49. Signature of health officer: <u>[Signature]</u></p>	
<p>50. Signature of registrar: <u>[Signature]</u></p>	
<p>51. Signature of undertaker: <u>[Signature]</u></p>	
<p>52. Signature of family: <u>[Signature]</u></p>	
<p>53. Signature of clergyman: <u>[Signature]</u></p>	
<p>54. Signature of coroner: <u>[Signature]</u></p>	
<p>55. Signature of health officer: <u>[Signature]</u></p>	
<p>56. Signature of registrar: <u>[Signature]</u></p>	
<p>57. Signature of undertaker: <u>[Signature]</u></p>	
<p>58. Signature of family: <u>[Signature]</u></p>	
<p>59. Signature of clergyman: <u>[Signature]</u></p>	
<p>60. Signature of coroner: <u>[Signature]</u></p>	
<p>61. Signature of health officer: <u>[Signature]</u></p>	
<p>62. Signature of registrar: <u>[Signature]</u></p>	
<p>63. Signature of undertaker: <u>[Signature]</u></p>	
<p>64. Signature of family: <u>[Signature]</u></p>	
<p>65. Signature of clergyman: <u>[Signature]</u></p>	
<p>66. Signature of coroner: <u>[Signature]</u></p>	
<p>67. Signature of health officer: <u>[Signature]</u></p>	
<p>68. Signature of registrar: <u>[Signature]</u></p>	
<p>69. Signature of undertaker: <u>[Signature]</u></p>	
<p>70. Signature of family: <u>[Signature]</u></p>	
<p>71. Signature of clergyman: <u>[Signature]</u></p>	
<p>72. Signature of coroner: <u>[Signature]</u></p>	
<p>73. Signature of health officer: <u>[Signature]</u></p>	
<p>74. Signature of registrar: <u>[Signature]</u></p>	
<p>75. Signature of undertaker: <u>[Signature]</u></p>	
<p>76. Signature of family: <u>[Signature]</u></p>	
<p>77. Signature of clergyman: <u>[Signature]</u></p>	
<p>78. Signature of coroner: <u>[Signature]</u></p>	
<p>79. Signature of health officer: <u>[Signature]</u></p>	
<p>80. Signature of registrar: <u>[Signature]</u></p>	
<p>81. Signature of undertaker: <u>[Signature]</u></p>	
<p>82. Signature of family: <u>[Signature]</u></p>	
<p>83. Signature of clergyman: <u>[Signature]</u></p>	
<p>84. Signature of coroner: <u>[Signature]</u></p>	
<p>85. Signature of health officer: <u>[Signature]</u></p>	
<p>86. Signature of registrar: <u>[Signature]</u></p>	
<p>87. Signature of undertaker: <u>[Signature]</u></p>	
<p>88. Signature of family: <u>[Signature]</u></p>	
<p>89. Signature of clergyman: <u>[Signature]</u></p>	
<p>90. Signature of coroner: <u>[Signature]</u></p>	
<p>91. Signature of health officer: <u>[Signature]</u></p>	
<p>92. Signature of registrar: <u>[Signature]</u></p>	
<p>93. Signature of undertaker: <u>[Signature]</u></p>	
<p>94. Signature of family: <u>[Signature]</u></p>	
<p>95. Signature of clergyman: <u>[Signature]</u></p>	
<p>96. Signature of coroner: <u>[Signature]</u></p>	
<p>97. Signature of health officer: <u>[Signature]</u></p>	
<p>98. Signature of registrar: <u>[Signature]</u></p>	
<p>99. Signature of undertaker: <u>[Signature]</u></p>	
<p>100. Signature of family: <u>[Signature]</u></p>	

10631

CERTIFICATE OF DEATH

10634

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN TB 3 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. STREET ADDRESS 933 MARYLAND AVENUE			
3. NAME OF DECEASED (Type or print) First MAXINE Middle ELIZABETH Last HAUPT				4. DATE OF DEATH Month SEPTEMBER Day 25 Year 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 13 1918	9. AGE (In years lost birthday) yrs. 40	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BOONSBORO WASH.CO.MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MELVIN M. JONES				14. MOTHER'S MAIDEN NAME PAULINE SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT 950 GUIBFO RD AVENUE MELVIN M. JONES HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brnchogenic carcinoma, right lung 162.1 DUE TO with mediastinal, cerebral, and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hepatic metastasis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 mon.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 131 W. Washington St., Hagerstown, MD.	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-23 , 19 58 , to 9-25 , 19 58 , that I last saw the deceased alive on 9-25 , 19 58 , and that death occurred at 10:40 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Kehne M.D. 131 W. Washington St., Hagerstown, MD.							
ACTUAL SIGNATURE John H. Kehne M.D.				PHYSICIAN'S NAME (Type) John H. Kehne M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		SEPT. 28 1958		BOONSBORO CEMETERY		BOONSBORO WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. East				ADDRESS Boonsboro Md		24a. REC'D BY REGISTRAR DATE OCT 1 '58	
						24b. REGISTRAR'S SIGNATURE Arthur S. Trans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. JONES		SEX Male	
AGE 40		DATE OF BIRTH 1916	
PLACE OF BIRTH Baltimore, Md.		OCCASION OF DEATH Heart Disease	
DATE OF DEATH 1956		TIME OF DEATH 10:00 AM	
PLACE OF DEATH Home		CAUSE OF DEATH Myocardial Infarction	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF JURY (None)		SIGNATURE OF JUDGE (None)	
SIGNATURE OF CLERK (None)		SIGNATURE OF REGISTRAR (None)	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10632

CERTIFICATE OF DEATH

10635

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>Christine</u> Last <u>HAWBAKER</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 3, 1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>6</u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cleaning Woman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington Co. Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Michael Neff</u>				14. MOTHER'S MAIDEN NAME <u>Elijali Bockman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217 09 9552</u>		17. INFORMANT Address <u>Mrs. Charles Hart Williamsport Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 20</u> to <u>Sept 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 10</u> , 19 <u>58</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>159 W. Washington St., Hagerstown, Md.</u> DATE SIGNED <u>9/12/58</u>							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>				M.D. <u>159 W. Washington St., Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 14-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Lash Williamsport, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

CERTIFICATE OF DEATH

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ALMA CORPUS AROLIN

10633

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. county Hospital</u>		d. STREET ADDRESS <u>1697 Salem Ave Extd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PREMATURE BABY BOY HOFFMAN</u>		4. DATE OF DEATH Month Day Year <u>September 26 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 26 1958</u>
9. AGE (In years last birthday) yrs. <u>15</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bruce N. Hoffman Jr</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Hamby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Bruce N. Hoffman Jr</u>		Address <u>1697 Salem Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (5 1/2 mwo)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Unknown</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>-----</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>26 Sept 58</u> to <u>26 Sept 58</u> , that I last saw the deceased alive on <u>26 Sept 58</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. D. Wilson</u>		ADDRESS (Street, city or town, state) <u>135 N. Baltimore St Hagerstown, MD</u>	
PHYSICIAN'S NAME (Type) <u>J. D. WILSON</u>		DATE SIGNED <u>9/27/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/27/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

208/311 XVO

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10637

10634

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b 52 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle Allen Last Johnson				4. DATE OF DEATH Month Sept Day 10 Year 19 58			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4 1904		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY gardener		11. BIRTHPLACE (State or foreign country) Fallingwater W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Johnson				14. MOTHER'S MAIDEN NAME Lillie Molly 185 Berkson Ave.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-12-2717		17. INFORMANT Address Mrs Esther Monroe 185 Berkson Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 289.2 DUE TO Porphyria Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/5/58 , 19 58 , to 9/10/58 , 19 58 , that I last saw the deceased alive on 9/10/58 , 19 58 , and that death occurred at 6:00 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 136 N. Potomac St. 9/15/58							
ACTUAL SIGNATURE Howard N. Weeks M.D.				PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-15-1958		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE SEP 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

10635

CERTIFICATE OF DEATH

Reg. Dist. No.

10638

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland			
c. LENGTH OF STAY IN 1b 47 yrs.				d. STREET ADDRESS 414 N. Jonathan Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 414 N. Jonathan Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rachel Middle Francis Last Johnson				4. DATE OF DEATH Month Sept Day 10 Year 19 58			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 9 1871	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Cedar Hill Va.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Peter Hamilton				14. MOTHER'S MAIDEN NAME Charlotte Gilbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Edna Wilkerson 414 N. Jonathan St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-1 , 19 51 , to 9-10 , 19 58 , that I last saw the deceased alive on 9-10-58 , 19 58 , and that death occurred at 6:13 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 137 W Washington DATE SIGNED 9-10-58 ACTUAL SIGNATURE Robert P. Couraqui M.D. PHYSICIAN'S NAME (Type) Robert P. Couraqui Hagerstown, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Buried	9-13-1958	Rose Hill Cemetery		Hagerstown Md			
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson				24a. REC'D BY REGISTRAR DATE SEP 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

NAME OF DECEASED J. J. JENNINGS		AGE 45		SEX Male		RACE White	
DATE OF DEATH Jan 10 1902		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
CAUSE OF DEATH Heart Disease		DISEASE Coronary Artery Disease		SYMPTOMS Chest pain, shortness of breath		TREATMENT None	
SIGNATURE OF PHYSICIAN J. J. JENNINGS		SIGNATURE OF WITNESS J. J. JENNINGS		SIGNATURE OF DECEASED J. J. JENNINGS		SIGNATURE OF NEXT OF KIN J. J. JENNINGS	
DATE OF SIGNATURE Jan 10 1902		DATE OF SIGNATURE Jan 10 1902		DATE OF SIGNATURE Jan 10 1902		DATE OF SIGNATURE Jan 10 1902	

10636

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 60 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELMER CHARLES JONES		4. DATE OF DEATH SEPT. 5 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/5/1883
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED WOOD WORKER		10b. KIND OF BUSINESS OR INDUSTRY FURNITURE CO.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME IVERSON S. JONES		14. MOTHER'S MAIDEN NAME SARAH HAUSE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-07-8377	
17. INFORMANT MR. HAROLD E. JONES		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic Heart Disease DUE TO (c) 7 mi.		INTERVAL BETWEEN ONSET AND DEATH 15 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Poly cystic Kidney		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 5, 1958 , to Sept 5, 1958 , that I last saw the deceased alive on Sept. 5, 1958 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lloyd A. Hoffman M.D.		ADDRESS (Street, city or town, state) 214 N. Potomac St Hagerstown Md	
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		DATE SIGNED Sept 9-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/8/58	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md		24a. REC'D BY REGISTRAR SEP 10 '58	
ADDRESS Hagerstown, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2420

10637

CERTIFICATE OF DEATH

Reg. Dist. No.

10640

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>8 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSPITAL</u>				d. STREET ADDRESS <u>2806 ELLICOT DRIVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				3. NAME OF DECEASED (Type or print) First <u>THELMA</u> Middle <u>KELLUM</u> Last <u>KELLUM</u>			
4. DATE OF DEATH Month <u>SEPT.</u> Day <u>11</u> Year <u>1958</u>				5. SEX <u>FEMALE</u>			
6. COLOR OR RACE <u>COLORED</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>DEC. 2, 1915</u>				9. AGE (In years last birthday) <u>42</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Gurry</u>				14. MOTHER'S MAIDEN NAME <u>Loretta Briscoe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BILATERAL LOBULAR PNEUMONIA</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (c) <u>CARCINOMA LEFT BREAST</u> INTERVAL BETWEEN ONSET OF DEATH <u>8 DAYS</u> <u>5 MONTHS</u> <u>4 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>SEPT. 3</u> , 19 <u>58</u> , to <u>SEPT. 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>SEPT. 11</u> , 19 <u>58</u> , and that death occurred at <u>10:44 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>George Beron, M.D.</u> ADDRESS <u>1500 PENNSYLVANIA AVE.</u> DATE <u>9/11/58</u>							
PHYSICIAN'S NAME (Type) <u>DR. G. BERON</u> ADDRESS <u>HAGERSTOWN, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>9-15-58</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>W.T. Calvary</u>							
22d. LOCATION (City, town, or county) (State) <u>A. A. Co. Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Adolphus Halstead 918 Druid Hill</u>							
24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>							
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Knapp</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10685 CERTIFICATE OF DEATH

10641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg				c. LENGTH OF STAY IN 1b 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) RFD 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maude Middle Ellen Last Kendall				4. DATE OF DEATH Month Sept. Day 4, Year 19 58			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1892	
9. AGE (In years lay birthday) 66 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress				10b. KIND OF BUSINESS OR INDUSTRY garment factory		11. BIRTHPLACE (State or foreign country) Frederick Co., Md.	
12. CITIZEN OF WHAT COUNTRY? Frederick Co., Md.							
13. FATHER'S NAME James Webb				14. MOTHER'S MAIDEN NAME Rosa Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-0390831		17. INFORMANT Mrs. Mable Ferguson, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 1 WK 5 yrs. 8 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 Month 11 Day 8 Year 1954 p. m. p.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Smithsburg, Md.	
20f. (City or town) Smithsburg, Md.				20g. (County) Washington			
20h. (State) Md.							
21. I certify that I attended the deceased from 11-8- , 19 54 , to 9-4- , 19 58 , that I last saw the deceased alive on 9-4- , 19 58 , and that death occurred at 9:30 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. Hess				ADDRESS (Street, city or town, state) Smithsburg, Md.			
PHYSICIAN'S NAME (Type) Charles F. Hess, Md.				DATE SIGNED 9-5-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-7-58		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home, Smithsburg, Md.				24a. REC'D BY REGISTRAR SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10686

CERTIFICATE OF DEATH

Reg. Dist. No. 10642

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BEESBORO</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MIDDLETOWN 10X-2</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KEEDY-FARNEY MEMORIAL HOME</u>				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>ESTELLE</u> Last <u>LIGHTER</u>				4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-28-1876</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER'S WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>JAMES O. BUSSARD</u>				14. MOTHER'S MAIDEN NAME <u>MARY WARREN FELTZ BUSSARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220</u>		17. INFORMANT <u>RICHARD LIGHTER, GETTYSBURG, PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>August 1, 1958</u> , to <u>Sept. 9, 1958</u> , that I last saw the deceased alive on <u>Sept 5, 1958</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. Livan</u>				ADDRESS (Street, city or town, state) <u>Barnesboro Md.</u>		DATE SIGNED <u>9/9/58</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Livan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-11-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MIDDLETOWN REFORMED</u>		22d. LOCATION (City, town, or county) (State) <u>MIDDLETOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GLADHILL Co.</u>				24a. REC'D BY REGISTRAR <u>SEP 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

10638

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OSCAR Middle ASA Last LUM				4. DATE OF DEATH Month SEPTEMBER Day 12 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 16 1880	
9. AGE (In years last birthday) 77 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRODUCE DEALER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) MT. LENA WASH. CO. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME WILLIAM S. LUM			
14. MOTHER'S MAIDEN NAME ELIZABETH BEACHLEY				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 219-05-2128				17. INFORMANT Address MRS. MARY E. LUM 210 EAST AVE. HAGERSTOWN			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by food 450.0 DUE TO Senile arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 minutes (c) years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 Diabetes mellitus, (fracture, l. humerus 5-58)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 5 , 19 58 , to 9-12 , 19 58 , that I last saw the deceased alive on Sept 12 , 19 58 , and that death occurred at 12:00 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert F. Keadle				ADDRESS (Street, city or town, state) Hagerstown			
PHYSICIAN'S NAME (Type) Robert F. Keadle, M. D., 318 N. Potomac St., Hagerstown, Md.				DATE SIGNED 9-13-58			
22a. BURIAL, CREMATION, REMOVAL, ETC.		22b. DATE THEREOF BURIAL SEPT. 14, 1958		22c. NAME OF CEMETERY OR CREMATORY MT. LENA CEMETERY		22d. LOCATION (City, town, or county) (State) MT. LENA WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Bast				24a. REC'D BY REGISTRAR DATE SEP 16 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Haus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10639

CERTIFICATE OF DEATH

10644

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 1/2 Days 03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				d. STREET ADDRESS <u>22 So Mulberry St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDITH BENCHOFF MARTIN</u>				4. DATE OF DEATH <u>September 24 19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25 1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Paramount Wash. Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David W. Benchoff</u>				14. MOTHER'S MAIDEN NAME <u>Olevia Oswald</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-7442</u>		17. INFORMANT <u>Howard V. Martin 23 So Mulberry St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>36 hrs.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept. 23, 1958</u> , to <u>Sept. 24, 1958</u> , that I last saw the deceased alive on <u>Sept. 24, 1958</u> , and that death occurred at <u>8 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u> M.D. <u>214 N. Potomac St</u>				DATE SIGNED <u>9/26/58</u>			
PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u> <u>Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> <u>Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10640

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 673 Highland Way e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nellie Bly Martin		4. DATE OF DEATH Sept 6 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1885
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Lushbaugh		14. MOTHER'S MAIDEN NAME Katherine Ridenour	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. 214-28-0757	
17. INFORMANT Mrs. Thelma Carbaugh		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition DUE TO 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma skull & scalp. DUE TO Path report, final, not available (c) 6-72 mo.		INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1958 to death 19 , that I last saw the deceased Sept. 6 19 58 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert F. Keadle M.D.		ADDRESS (Street, city or town, state) 318 N. Potomac St	
PHYSICIAN'S NAME (Type) Robert F. Keadle		DATE SIGNED 9-8-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR SEP 9 1958		24b. REGISTRAR'S SIGNATURE Arthur L. Keadle	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10641

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Greencastle</u> 75x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Memorial Home</u>				d. STREET ADDRESS <u>Route #1</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Elmer</u> Last <u>Mayhugh</u>				4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/21/1873</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>George W. Mayhugh</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Gossard</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>176-01-5419</u>		17. INFORMANT <u>Mr. Lester Reig, Greencastle Rd #1, Pa</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 July</u> , 19 <u>57</u> , to <u>17 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 Sept</u> , 19 <u>58</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edna D. Houchland</u> M.D.				ADDRESS (Street, city or town, state) <u>115 W. Wash St Hagerstown Md</u>			
PHYSICIAN'S NAME (Type) <u>Edna D. Houchland</u>				DATE SIGNED <u>9/18/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beautiful View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>State Line Wash Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman</u>				ADDRESS <u>Greencastle, Pa</u>		24a. REC'D BY REGISTRAR <u>SEP 19 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hahn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10642

CERTIFICATE OF DEATH

10647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>45 MIN.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X HANCOCK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL</u> <u>N.M.N.</u> <u>MCCARTY</u>			4. DATE OF DEATH Month Day Year <u>SEPTEMBER</u> <u>14</u> <u>1958</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPTEMBER 14</u>		9. AGE (In years last birthday) yrs. <u>45</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. <u>45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>PAUL EUGENE MCCARTY</u>				14. MOTHER'S MAIDEN NAME <u>DOLLY ADDLINE WELLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MOTHER</u> <u>HANCOCK MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>45 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Premature Delivery 5 1/2 - 6 mos.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel F. Waddill</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>115 King ST. Hagerstown</u> <u>9/14/58</u>					
PHYSICIAN'S NAME (Type) <u>DR. S.F. WADDILL HAGERSTOWN, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>9/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington County Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>2081213XVO</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>9-17-58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thorne</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12/5/29		6. BIRTH PLACE Jackson, Mississippi	
7. DECEASED DATE 4/4/68		8. DECEASED TIME 10:00 AM		9. DECEASED PLACE FBI Office, Memphis, Tennessee	
10. DECEASED CAUSE Suicide		11. DECEASED MANNER Homicide		12. DECEASED MANNER Suicide	
13. DECEASED MANNER Suicide		14. DECEASED MANNER Suicide		15. DECEASED MANNER Suicide	
16. DECEASED MANNER Suicide		17. DECEASED MANNER Suicide		18. DECEASED MANNER Suicide	
19. DECEASED MANNER Suicide		20. DECEASED MANNER Suicide		21. DECEASED MANNER Suicide	
22. DECEASED MANNER Suicide		23. DECEASED MANNER Suicide		24. DECEASED MANNER Suicide	
25. DECEASED MANNER Suicide		26. DECEASED MANNER Suicide		27. DECEASED MANNER Suicide	
28. DECEASED MANNER Suicide		29. DECEASED MANNER Suicide		30. DECEASED MANNER Suicide	
31. DECEASED MANNER Suicide		32. DECEASED MANNER Suicide		33. DECEASED MANNER Suicide	
34. DECEASED MANNER Suicide		35. DECEASED MANNER Suicide		36. DECEASED MANNER Suicide	
37. DECEASED MANNER Suicide		38. DECEASED MANNER Suicide		39. DECEASED MANNER Suicide	
40. DECEASED MANNER Suicide		41. DECEASED MANNER Suicide		42. DECEASED MANNER Suicide	
43. DECEASED MANNER Suicide		44. DECEASED MANNER Suicide		45. DECEASED MANNER Suicide	
46. DECEASED MANNER Suicide		47. DECEASED MANNER Suicide		48. DECEASED MANNER Suicide	
49. DECEASED MANNER Suicide		50. DECEASED MANNER Suicide		51. DECEASED MANNER Suicide	
52. DECEASED MANNER Suicide		53. DECEASED MANNER Suicide		54. DECEASED MANNER Suicide	
55. DECEASED MANNER Suicide		56. DECEASED MANNER Suicide		57. DECEASED MANNER Suicide	
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1. NAME OF DECEASED
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3. AGE
4. RACE
5. BIRTH DATE
6. BIRTH PLACE
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8. DECEASED TIME
9. DECEASED PLACE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10643

CERTIFICATE OF DEATH

10648

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Virginia b. COUNTY Morgan			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkeley Springs 85x-3				d. STREET ADDRESS none			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SHERRY Middle DIANE Last MC CUMBER				4. DATE OF DEATH Month September Day 15 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1956	
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		IF UNDER 24 HRS. Months 2 Days 2 Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Berkeley Spring, W. Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Phyllis Marie Mc Cumbee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Phyllis M. Mc Cumbee Berkeley Springs, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Brain tumor in region of IV Vent. operated on 9/12/1958 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 237x (c) 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Berkeley Springs, W. Va.				20g. (County) Berkeley		20h. (State) W. Va.	
21. I certify that I attended the deceased from 9/10/58 , 19 58 , to 9/15/58 , 19 58 , that I last saw the deceased alive on 9/15 , 19 58 , and that death occurred at 9:25 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 132 N. Potomac St., Hagerstown, Md. DATE SIGNED 9/15/58							
ACTUAL SIGNATURE A. F. Abdullah				PHYSICIAN'S NAME (Type) A. F. Abdullah, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/1958		22c. NAME OF CEMETERY OR CREMATORY Greenway Cemetery		22d. LOCATION (City, town, or county) (State) Berkeley Springs, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE SEP 18 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanes			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and send them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9, Film G234, 10/6/58
10687
CERTIFICATE OF DEATH

10649

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS Rural 1 Hancock Md.	
3. NAME OF DECEASED (Type or print) First Raleigh Middle Ellis Last McCusker		4. DATE OF DEATH Month 9 Day 23 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.8.1907
9. AGE (In years last birthday) 52 1/2 yrs.		IF UNDER 1 YEAR Months 3 Days 14	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill	11. BIRTHPLACE (State or foreign country) Washington County Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas G McCusker	
14. MOTHER'S MAIDEN NAME Florence L Barnhart		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Miss Mathield McCucker Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arricular fibrillation DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 10 months Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 29 , 19 58 , to Sept 23 , 19 58 , that I last saw the deceased alive on Sept 23 , 19 58 , and that death occurred at 7 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE G.O. Martin		ADDRESS (Street, city or town, state) 111 S. Spring St. Martinsburg W. Va.	
PHYSICIAN'S NAME (Type) G.O. Martin, M.D.		DATE SIGNED 111 S. Spring ST. Martinsburg, W. Va.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9.27.58	22c. NAME OF CEMETERY OR CREMATORY Mt Olivet	22d. LOCATION (City, town, or county) (State) Rural Hancock Washington MD
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Shore Hancock Md.		ADDRESS 	
24a. REC'D BY REGISTRAR SEP 30 '58		24b. REGISTRAR'S SIGNATURE Charles E. Hines	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES HANCOCK		AGE 70	SEX Male	RACE White	DATE OF BIRTH 1880
PLACE OF BIRTH Baltimore, Md.		DATE OF DEATH 1950			
RESIDENCE Baltimore, Md.		CAUSE OF DEATH Heart Disease			
OCCUPATION Retired		MANNER OF DEATH Natural			
EDUCATION High School		RELIGION Roman Catholic			
MARRIAGE Married		SPOUSE Mary H. Hancock			
FAMILY HISTORY None		PREVIOUS ILLNESS None			
SIGNS AND SYMPTOMS None		TESTS None			
TREATMENT None		PATHOLOGICAL FINDINGS None			
POST-MORTEM None		LABORATORY TESTS None			
BURIAL None		CEREMONY None			
FUNERAL HOME None		CITY Baltimore			
COUNTY Baltimore		STATE Maryland			
SIGNATURE OF PHYSICIAN None		SIGNATURE OF REGISTRAR None			
DATE None		TIME None			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
COUNTY SIGNATURE <i>S. Robert Wells M.D.</i>										
DHE. Death No. <i>10644</i> 10650										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 22 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL					d. STREET ADDRESS / 19 W. WASHINGTON ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATIE Middle MAY Last MILLER					4. DATE OF DEATH Month SEPTEMBER Day 25 Year 19 58					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/6/1875		9. AGE (In years last birthday) 82		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM DAMUTH					14. MOTHER'S MAIDEN NAME ROSELLA PEARL					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. ROSELLA FRALEY			Address HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture Femur DUE TO (c) Hypertensive Arteriosclerotic Heart Disease								INTERVAL BETWEEN ONSET AND DEATH 10 days 10 day 10 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from chair						
20c. TIME OF INJURY Hour - o. m. 9-13 p. m. 58				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Washington Md		
21. I certify that I attended the deceased from 9-13-1958 to 9-15-1958 , that I last saw the deceased alive on 9-14-1958 , and that death occurred at 3 A M, from the causes and on the date stated above.										
ACTUAL SIGNATURE S. E. Wells					ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 9/26/58					
PHYSICIAN'S NAME (Type) Dr E. W. T. Tag										
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/27/58		22c. NAME OF CEMETERY OR CREMATORY EV. U.B. CHURCH CEM.			22d. LOCATION (City, town, or county) (State) THURMONT MD.			
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment					ADDRESS Hagerstown Md		24a. REC'D BY REGISTRAR DATE SEP 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10651

10688

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown RFD #3</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hagerstown Md. RFD #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ESTELLA</u> Middle <u>MONGAN</u> Last <u>MONGAN</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 5 1868</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u>17</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>William Mongan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Boyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Bessie Mongan</u>		Address <u>Hagerstown Md. R. F. D. #3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>Emphysema</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>5 1/2 hrs</u> <u>10</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1934</u> , 19 <u> </u> , to <u>9/23/58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>9/23/58</u> , 19 <u> </u> , and that death occurred at <u>4</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>SEARL YOUNG</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>9/24/58</u>	
PHYSICIAN'S NAME (Type) <u>SEARL YOUNG MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 26-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Leal Williamsport</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 26 '58</u>	
ADDRESS <u>Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. DATE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. PLACE OF DEATH</p>		<p>16. SIGNATURE OF WITNESSES</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF NEXT OF KIN</p>	
<p>19. SIGNATURE OF CLERGYMAN</p>		<p>20. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>21. SIGNATURE OF FUNERAL HOME</p>		<p>22. SIGNATURE OF CEMETERY</p>	
<p>23. SIGNATURE OF INTERMENT</p>		<p>24. SIGNATURE OF REINTERMENT</p>	
<p>25. SIGNATURE OF REINTERMENT</p>		<p>26. SIGNATURE OF REINTERMENT</p>	
<p>27. SIGNATURE OF REINTERMENT</p>		<p>28. SIGNATURE OF REINTERMENT</p>	
<p>29. SIGNATURE OF REINTERMENT</p>		<p>30. SIGNATURE OF REINTERMENT</p>	
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<p>55. SIGNATURE OF REINTERMENT</p>		<p>56. SIGNATURE OF REINTERMENT</p>	
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<p>67. SIGNATURE OF REINTERMENT</p>		<p>68. SIGNATURE OF REINTERMENT</p>	
<p>69. SIGNATURE OF REINTERMENT</p>		<p>70. SIGNATURE OF REINTERMENT</p>	
<p>71. SIGNATURE OF REINTERMENT</p>		<p>72. SIGNATURE OF REINTERMENT</p>	
<p>73. SIGNATURE OF REINTERMENT</p>		<p>74. SIGNATURE OF REINTERMENT</p>	
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<p>77. SIGNATURE OF REINTERMENT</p>		<p>78. SIGNATURE OF REINTERMENT</p>	
<p>79. SIGNATURE OF REINTERMENT</p>		<p>80. SIGNATURE OF REINTERMENT</p>	
<p>81. SIGNATURE OF REINTERMENT</p>		<p>82. SIGNATURE OF REINTERMENT</p>	
<p>83. SIGNATURE OF REINTERMENT</p>		<p>84. SIGNATURE OF REINTERMENT</p>	
<p>85. SIGNATURE OF REINTERMENT</p>		<p>86. SIGNATURE OF REINTERMENT</p>	
<p>87. SIGNATURE OF REINTERMENT</p>		<p>88. SIGNATURE OF REINTERMENT</p>	
<p>89. SIGNATURE OF REINTERMENT</p>		<p>90. SIGNATURE OF REINTERMENT</p>	
<p>91. SIGNATURE OF REINTERMENT</p>		<p>92. SIGNATURE OF REINTERMENT</p>	
<p>93. SIGNATURE OF REINTERMENT</p>		<p>94. SIGNATURE OF REINTERMENT</p>	
<p>95. SIGNATURE OF REINTERMENT</p>		<p>96. SIGNATURE OF REINTERMENT</p>	
<p>97. SIGNATURE OF REINTERMENT</p>		<p>98. SIGNATURE OF REINTERMENT</p>	
<p>99. SIGNATURE OF REINTERMENT</p>		<p>100. SIGNATURE OF REINTERMENT</p>	

10645

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>		d. STREET ADDRESS <u>Lombard St.</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs Amy A. Munschour</u>		4. DATE OF DEATH <u>SEPTEMBER 15 1958</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 11, 1888</u>	
9. AGE (In years last birthday) <u>70</u>		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David S. Rice</u>		14. MOTHER'S MAIDEN NAME <u>Orie B. Fout</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Irvin L. Rice</u>		Address <u>Alexandria, Virginia</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AURICULAR FIBRILLATION PULMONARY EDEMA; PNEUMONITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIO VASCULAR RENAL DISEASE</u> DUE TO (c) <u>BRONCHIECTESIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>3 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. g. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT 5 1958</u> , to <u>SEPT 15 1958</u> , that I last saw the deceased alive on <u>SEPT 15 1958</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>PROFESSIONAL ARTS BUILDING, HGSTN. MD.</u> DATE SIGNED <u>Raymond E. Creager</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 19 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

Form No. 10

DEPARTMENT OF HEALTH - BUREAU OF VITALS DIVISION OF VITAL RECORDS		STATE OF NEW YORK COUNTY OF ALBANY	
NAME OF DECEASED David A. Rice		SEX Male	
DATE OF DEATH Dec. 11, 1988		TIME OF DEATH 10:00 AM	
PLACE OF DEATH Home		CITY OF DEATH Albany, N.Y.	
AGE 68		RACE White	
MARRIAGE Married		OCCUPATION Retired	
BIRTH Dec. 11, 1920		PLACE OF BIRTH Albany, N.Y.	
FATHER John A. Rice		MOTHER Mary A. Rice	
PREVIOUS MARRIAGES None		PREVIOUS DEATHS None	
CAUSE OF DEATH Natural Causes		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED David A. Rice		SIGNATURE OF WITNESS John A. Rice	
SIGNATURE OF PHYSICIAN Dr. J. A. Rice		SIGNATURE OF CLERK J. A. Rice	
SIGNATURE OF REGISTRAR J. A. Rice		SIGNATURE OF DECEASED David A. Rice	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10653

10646

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 Days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown					
f. STREET ADDRESS 829 W. Washington St.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Vincent Middle Calvin Last Murray				4. DATE OF DEATH Month 9 Day 13 Year 1958					
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 23, 1892			
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 8 Days 21 Hours Min. 		11. BIRTHPLACE (State or foreign country) Washington County		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Western Railroad.				10b. KIND OF BUSINESS OR INDUSTRY Washington County					
13. FATHER'S NAME Stephen F Murray				14. MOTHER'S MAIDEN NAME Susie Mills					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 					
17. INFORMANT Anna K Murray				Address Hagerstown Md 829 W. Washington St.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvular - Squared Colon 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Parkinson's Disease. DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH 2 days 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month 9 Day 19 Year 1958 Hour o. m. p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from Sept 1, 1956 to Sept 13, 1958 , that I last saw the deceased alive on Sept 13, 1958 , and that death occurred at 11:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 159 W. Washington St. Hagerstown, Md. DATE SIGNED 9/16/58									
ACTUAL SIGNATURE Philip J. Hirshman				M.D. 159 W. Washington St. Hagerstown, Md.					
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9.17.58		22c. NAME OF CEMETERY OR OCEANORY Park Head U.B.		22d. LOCATION (City, town, or county) (State) Park Head Washington Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Howard F. Stone				ADDRESS Howard F. Stone		24a. REG'D. BY REGISTRAR SEP 19 58			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				DATE SEP 19 58					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10654

10689

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md.</u>		c. LENGTH OF STAY IN 1b <u>63 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>112 W. Potomac Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grover</u> Middle <u>Cleveland</u> Last <u>Palmer</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Leather Trimmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tannery</u>	11. BIRTHPLACE (State or foreign country) <u>Williamsport Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Nathan Palmer</u>	
14. MOTHER'S MAIDEN NAME <u>Frances Howard</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>	
16. SOCIAL SECURITY NO. <u>215 09 7418</u>		17. INFORMANT <u>Mrs. Edith Palmer Williamsport Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma</u> (c) <u>Bladder Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8</u> <u>4 wks</u> <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 21</u> , 19 <u>58</u> , to <u>Sept 17</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Sept 16</u> , 19 <u>58</u> , and the death occurred at <u>5:27</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M E Byrkit</u>		ADDRESS (Street, city or town, state) <u>28 W. Potomac Williamsport, Md</u>	
PHYSICIAN'S NAME (Type) <u>M. E. Byrkit, M.D.</u>		DATE SIGNED <u>9-18-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 20-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L Leaf</u>		24a. REC'D BY REGISTRAR <u>SEP 19 '58</u>	
ADDRESS <u>Williamsport, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 26

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10655

Reg. Dist. No. 302

10647

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>25 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1685 Salem Ave.</u>				d. STREET ADDRESS <u>1685 Salem Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>JESSE</u> Last <u>PAYNE</u>			4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1881</u>		9. AGE (in years last birthday) <u>77 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>		11. BIRTHPLACE (State or foreign country) <u>near Berryville; Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Henry Payne</u>			14. MOTHER'S MAIDEN NAME <u>Rowenna Catherine Barr</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>174-20-9364A</u>		17. INFORMANT Address <u>Mrs. Lucy Payne Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>None 19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>Oct. 1 '58</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/2/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Paul Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Boyer</u>		ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Cause of Death		Place of Death		Occupation		Residence	
Manner of Death		Signature of Examiner		Signature of Coroner		Signature of Physician	
Medical History		Physical Examination		Mental Examination		Autopsy	
Toxicology		Microscopic Examination		Bacteriology		Chemistry	
Radiology		Pathology		Immunology		Genetics	
Other		Other		Other		Other	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10648

CERTIFICATE OF DEATH

Reg. Dist. No.

11819

1. PLACE OF DEATH a. COUNTY <u>Washington County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>25 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BABY</u> First Middle Last <u>PIPER</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 30, 1958</u>	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Richard E. Piper</u>		14. MOTHER'S MAIDEN NAME <u>Greta Marlene Troupe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immature labor</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Unknown</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>25 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>51.</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Sept. 30</u> , 19 <u>58</u> , to <u>Sept. 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 30</u> , 19 <u>58</u> , and that death occurred at <u>4:50P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John D. Turco</u> M.D.				PHYSICIAN'S NAME (Type) <u>John D. Turco, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>10/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Co. Hospital</u>	
22d. LOCATION (City, town, or county) <u>Hagerstown, Md.</u>				22e. LOCATION (State) <u>Md.</u>		22f. LOCATION (Country) <u>U.S.A.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>OCT 20 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hand</u>				24c. REGISTRAR'S NAME <u>Arthur S. Hand</u>			

2081262XVV

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>		<p>3. AGE _____</p>	
<p>4. DATE OF DEATH _____</p>		<p>5. TIME OF DEATH _____</p>		<p>6. PLACE OF DEATH _____</p>	
<p>7. OCCASION OF DEATH _____</p>		<p>8. CAUSE OF DEATH _____</p>		<p>9. MANNER OF DEATH _____</p>	
<p>10. SIGNATURE OF PHYSICIAN _____</p>		<p>11. SIGNATURE OF CORONER _____</p>		<p>12. SIGNATURE OF WITNESS _____</p>	
<p>13. SIGNATURE OF DECEASED _____</p>		<p>14. SIGNATURE OF NEXT OF KIN _____</p>		<p>15. SIGNATURE OF BURIAL SOCIETY _____</p>	
<p>16. SIGNATURE OF CHURCH _____</p>		<p>17. SIGNATURE OF FUNERAL HOME _____</p>		<p>18. SIGNATURE OF CEMETERY _____</p>	
<p>19. SIGNATURE OF STATE DEPARTMENT OF HEALTH _____</p>		<p>20. SIGNATURE OF BALTIMORE CITY DEPARTMENT OF HEALTH _____</p>		<p>21. SIGNATURE OF BALTIMORE COUNTY DEPARTMENT OF HEALTH _____</p>	



THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD, AND IN THE BALTIMORE CITY DEPARTMENT OF HEALTH, BALTIMORE, MD, AND IN THE BALTIMORE COUNTY DEPARTMENT OF HEALTH, BALTIMORE, MD.

10690

CERTIFICATE OF DEATH

10656

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL				c. LENGTH OF STAY IN 1b 3 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GATEWAY NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JESSE ALVERDA PRYOR				4. DATE OF DEATH Month Day Year SEPTEMBER 7 1958 19			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 27 1900	9. AGE (In years last birthday) yrs. 58	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WAYNESBORO PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHRISTIAN TRACE				14. MOTHER'S MAIDEN NAME ELIZABETH S. SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address EDGAR P. PRYOR HAGERSTOWN MD.R.1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 345X Respiratory Paralysis DUE TO (b) Multiple Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 7 hours 20 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 58 to 7 Sept 58 , that I last saw the deceased alive on 3 Sept 1958 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. D. Wilson				ADDRESS (Street, city or town, state) DATE SIGNED 135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND 9/8/58			
PHYSICIAN'S NAME (Type) J. D. WILSON, M.D.							
22a. BURIAL, CREMATION, REMAINS (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		SEPT. 10 1958		BEAVER CREEK CEMETERY		BEAVER CREEK WASH.CO.MD	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John E. East Boonsboro Md.				24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10649

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>24 Clinton Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>LEVAN</u> Last <u>RAUP, JR.</u>				4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1914</u>	9. AGE (In years lost birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prof. Photographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Fairmont, W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar L. Raup, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Louise Frew</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>210-03-6923</u>		17. INFORMANT Address <u>Mrs. Mary L. Raup Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction with Ventricular Fibrillation</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiac-vascular Disease Class I A</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/5</u> , 19 <u>57</u> , to <u>9/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/15</u> , 19 <u>58</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dalton M. Welty</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown, Maryland</u> DATE SIGNED <u>9/16/58</u>			
PHYSICIAN'S NAME (Type) <u>DALTON M. WELTY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/18/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. Franklin Rouzer</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10691

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sandy Hook		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sandy Hook	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION *		d. STREET ADDRESS / *	
3. NAME OF DECEASED (Type or print) Dottie First Levetta Middle Redman Last		4. DATE OF DEATH 9 Month 5 Day 1958 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-1882
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Tritapoe	
14. MOTHER'S MAIDEN NAME Alverta Hough		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Richard Hawker Jefferson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatoid arthritis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-17 1958 , to 9-5 1958 , that I last saw the deceased alive on 9-5 1958 , and that death occurred at 7:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 So. Maryland Ave. DATE SIGNED 9-6-58			
ACTUAL SIGNATURE C. T. Byron Kao M.D.		PHYSICIAN'S NAME (Type) C. T. Byron Kao, M.D. Brunswick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-8-1958	22c. NAME OF CEMETERY OR CREMATORY Reformed	22d. LOCATION (City, town, or county) (State) Knoxville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Fute ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR SEP 10 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Small α Large α

Page 8 of 14

Ernst, J. 1990. *Journal of the American Water Resources Association* 26: 101-110.

10650

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerston</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PAULINE</u> Middle <u>LIVINGSTON</u> Last <u>REICHARD</u>				4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 28 1877</u>	9. AGE (In years last birthday) yrs. <u>81</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State, or foreign country) <u>Huntingdon Co Huntingdon Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dr G. L. Robb</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Daniel L. Reichard</u> Address <u>1315 Oak Hill Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>433.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3-2-1955</u> , 19 <u> </u> , to <u>9-17-58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>9-17-58</u> , 19 <u> </u> , and that death occurred at <u>12 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>318 N. Potomac St. Hagerstown, Md.</u> DATE SIGNED <u>9-18-58</u>							
ACTUAL SIGNATURE <u>Paul Harrison</u> M.D.				318 N. Potomac St. 9-18-58			
PHYSICIAN'S NAME (Type) <u>Robert F. Keadle, M. D.</u> Partners				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10651

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 5</u>		c. LENGTH OF STAY IN 1b <u>22 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Forge Road</u>		e. STREET ADDRESS <u>Old Forge Road</u>	
3. NAME OF DECEASED (Type or print) First <u>KEMP</u> Middle <u>-----</u> Last <u>REYNOLDS</u>		4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 11 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Cavetown Wash. Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>No Record</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Reynolds</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>314-36-0438</u>	
17. INFORMANT <u>R. Atlee Reynolds</u>		Address <u>Hagerstown R # 5</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mixed malignant tumor of Left Breast</u> DUE TO <u>142.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1</u> , 19 <u>57</u> , to <u>9-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-18</u> , 19 <u>58</u> , and that death occurred at <u>12:40</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. Hess</u>		ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u> DATE SIGNED <u>9-23-58</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mil ers Mennonite Cemetery near Leitersburg Md</u>		22d. LOCATION (City, town, or county) <u>Wash Co</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10661

10652

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Rice</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 20 1910</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Fairplay Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Downs</u>				14. MOTHER'S MAIDEN NAME <u>Mary Della Leshner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219 36 3836</u>		17. INFORMANT Address <u>Mr. Lewis Rice Fairplay Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma to lungs</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of breast</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 mo.</u> <u>2 yr. 3 mo.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>55</u> , to <u>Sept 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>58</u> , and that death occurred at <u>5:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u> M.D.				ADDRESS (Street, city or town, state) <u>214 N. Potomac St. Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>				DATE SIGNED <u>Sept 21-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Lee Williams</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hauer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10653

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 Weeks</u> X <u>Hagerstown R # 4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				d. STREET ADDRESS <u>Broadfording Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>EDWARD</u> Last <u>RINGER</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1 1894</u>	
9. AGE (In years last birthday) yrs. <u>64</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y.C. Iron Wks</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Silas Peter Ringer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Johnston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>W.W.# 1</u>				16. SOCIAL SECURITY NO. <u>317-10-2704</u>		17. INFORMANT <u>Mrs Cordelia Ringer Hagerstown Md R #4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2</u> DUE TO <u>Carcinoma of Bladder & prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>none</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April</u> 19 <u>58</u> to <u>Sept. 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 12</u> , 19 <u>58</u> , and that death occurred at <u>12:10A</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D. <u>115 N. Potomac Street</u>							
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem E & R Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gearfoss Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Wells</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10663

10654

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS Washington Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First Henry Middle Robinson Last				4. DATE OF DEATH Month Sept. Day 22 Year 1958			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 14, 1889	
9. AGE (In years last birthday) yrs. 69		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Smithsburg, Md.	
13. FATHER'S NAME Albert Robinson				14. MOTHER'S MAIDEN NAME Alice Toms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-4980		17. INFORMANT Clyde O. Smith, Smithsburg, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary heart disease with 434 DUE TO myocardial failure grade iv Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchial asthma						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. none p. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) - - -	
21. I certify that I attended the deceased from Oct. 1956 , to Sept. 22, 1958 , that I last saw the deceased alive on Sept. 22, 1958 , and that death occurred at 9:45 p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Robert Wells		M.D. 115 N. Potomac Street		ADDRESS (Street, city or town, state)		DATE SIGNED 9-23-58	
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.		Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-26-58		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				ADDRESS SEP 25 '58		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

10655

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 35 Maple Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mable Middle Grace Last Romesberg				4. DATE OF DEATH Month Sept. Day 17 Year 1958			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY 705-10-5660		11. BIRTHPLACE (State or foreign country) Leitersburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Smith				14. MOTHER'S MAIDEN NAME Mary Kayhoe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Theodore Romesberg, Smithsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO Myocardial Infarction (c)							INTERVAL BETWEEN ONSET AND DEATH 1 Year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Oct 30, 1957 , to Sept 17, 1958 , that I last saw the deceased alive on Sept 16, 1958 , and that death occurred at 11:17 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. E. W. Smith				ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 9/17/58			
PHYSICIAN'S NAME (Type) Dr. E. W. Smith							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-20-58		22c. NAME OF CEMETERY OR CREMATORY Leitersburg Cemetery		22d. LOCATION (City, town, or county) (State) Leitersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				24a. REC'D BY REGISTRAR SEP 22 '58		24b. REGISTRAR'S SIGNATURE C. F. L. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10753

DATE OF DEATH 10/17/30

Dr. J. M. Smith
Dr. J. M. Smith

Dr. J. M. Smith
Dr. J. M. Smith

Dr. J. M. Smith
Dr. J. M. Smith

Dr. J. M. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10656

CERTIFICATE OF DEATH

Reg. Dist. No. 10665

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
				d. STREET ADDRESS 414 Freemont St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle OTTERBEIN Last ST CLAIR				4. DATE OF DEATH Month Sept. Day 26 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug 6, 1900		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Penna. Railroa d		11. BIRTHPLACE (State or foreign country) Franklin County, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Victor M. St Clair				14. MOTHER'S MAIDEN NAME Ella Mae Mummert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 717-07-9364		17. INFORMANT Mrs. Albert Sampson		Address 498 Mitchell Ave Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 420.1 DUE TO arterial embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction (c) Myocardial thrombosis INTERVAL BETWEEN ONSET AND DEATH 2 days 3 WK							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Occlusion 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept 18, 1958 to Sept 26, 1958 , that I last saw the deceased alive on Sept 26, 1958 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis G. Graft		M.D.		ADDRESS (Street, city or town, state) 119 E. Antietam Hagerstown		DATE SIGNED 9/29/58	
PHYSICIAN'S NAME (Type) Louis G. Graft MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/29/58	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.				ADDRESS 1601 Penna. Ave. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE SEP 30 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>Charles W. Smith</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 15, 1880</i></p>		<p>4. Age: <i>30 years</i></p>	
<p>5. Place of birth: <i>St. Louis, Mo.</i></p>		<p>6. Date of death: <i>Jan 22, 1910</i></p>	
<p>7. Cause of death: <i>Heart disease</i></p>		<p>8. Place of death: <i>St. Louis, Mo.</i></p>	
<p>9. Signature of physician: <i>Wm. H. Smith</i></p>		<p>10. Signature of registrar: <i>John D. Smith</i></p>	
<p>11. Signature of informant: <i>John D. Smith</i></p>		<p>12. Signature of witness: <i>John D. Smith</i></p>	
<p>13. Signature of registrar: <i>John D. Smith</i></p>		<p>14. Signature of witness: <i>John D. Smith</i></p>	
<p>15. Signature of informant: <i>John D. Smith</i></p>		<p>16. Signature of witness: <i>John D. Smith</i></p>	
<p>17. Signature of registrar: <i>John D. Smith</i></p>		<p>18. Signature of witness: <i>John D. Smith</i></p>	
<p>19. Signature of informant: <i>John D. Smith</i></p>		<p>20. Signature of witness: <i>John D. Smith</i></p>	
<p>21. Signature of registrar: <i>John D. Smith</i></p>		<p>22. Signature of witness: <i>John D. Smith</i></p>	
<p>23. Signature of informant: <i>John D. Smith</i></p>		<p>24. Signature of witness: <i>John D. Smith</i></p>	
<p>25. Signature of registrar: <i>John D. Smith</i></p>		<p>26. Signature of witness: <i>John D. Smith</i></p>	
<p>27. Signature of informant: <i>John D. Smith</i></p>		<p>28. Signature of witness: <i>John D. Smith</i></p>	
<p>29. Signature of registrar: <i>John D. Smith</i></p>		<p>30. Signature of witness: <i>John D. Smith</i></p>	
<p>31. Signature of informant: <i>John D. Smith</i></p>		<p>32. Signature of witness: <i>John D. Smith</i></p>	
<p>33. Signature of registrar: <i>John D. Smith</i></p>		<p>34. Signature of witness: <i>John D. Smith</i></p>	
<p>35. Signature of informant: <i>John D. Smith</i></p>		<p>36. Signature of witness: <i>John D. Smith</i></p>	
<p>37. Signature of registrar: <i>John D. Smith</i></p>		<p>38. Signature of witness: <i>John D. Smith</i></p>	
<p>39. Signature of informant: <i>John D. Smith</i></p>		<p>40. Signature of witness: <i>John D. Smith</i></p>	
<p>41. Signature of registrar: <i>John D. Smith</i></p>		<p>42. Signature of witness: <i>John D. Smith</i></p>	
<p>43. Signature of informant: <i>John D. Smith</i></p>		<p>44. Signature of witness: <i>John D. Smith</i></p>	
<p>45. Signature of registrar: <i>John D. Smith</i></p>		<p>46. Signature of witness: <i>John D. Smith</i></p>	
<p>47. Signature of informant: <i>John D. Smith</i></p>		<p>48. Signature of witness: <i>John D. Smith</i></p>	
<p>49. Signature of registrar: <i>John D. Smith</i></p>		<p>50. Signature of witness: <i>John D. Smith</i></p>	
<p>51. Signature of informant: <i>John D. Smith</i></p>		<p>52. Signature of witness: <i>John D. Smith</i></p>	
<p>53. Signature of registrar: <i>John D. Smith</i></p>		<p>54. Signature of witness: <i>John D. Smith</i></p>	
<p>55. Signature of informant: <i>John D. Smith</i></p>		<p>56. Signature of witness: <i>John D. Smith</i></p>	
<p>57. Signature of registrar: <i>John D. Smith</i></p>		<p>58. Signature of witness: <i>John D. Smith</i></p>	
<p>59. Signature of informant: <i>John D. Smith</i></p>		<p>60. Signature of witness: <i>John D. Smith</i></p>	
<p>61. Signature of registrar: <i>John D. Smith</i></p>		<p>62. Signature of witness: <i>John D. Smith</i></p>	
<p>63. Signature of informant: <i>John D. Smith</i></p>		<p>64. Signature of witness: <i>John D. Smith</i></p>	
<p>65. Signature of registrar: <i>John D. Smith</i></p>		<p>66. Signature of witness: <i>John D. Smith</i></p>	
<p>67. Signature of informant: <i>John D. Smith</i></p>		<p>68. Signature of witness: <i>John D. Smith</i></p>	
<p>69. Signature of registrar: <i>John D. Smith</i></p>		<p>70. Signature of witness: <i>John D. Smith</i></p>	
<p>71. Signature of informant: <i>John D. Smith</i></p>		<p>72. Signature of witness: <i>John D. Smith</i></p>	
<p>73. Signature of registrar: <i>John D. Smith</i></p>		<p>74. Signature of witness: <i>John D. Smith</i></p>	
<p>75. Signature of informant: <i>John D. Smith</i></p>		<p>76. Signature of witness: <i>John D. Smith</i></p>	
<p>77. Signature of registrar: <i>John D. Smith</i></p>		<p>78. Signature of witness: <i>John D. Smith</i></p>	
<p>79. Signature of informant: <i>John D. Smith</i></p>		<p>80. Signature of witness: <i>John D. Smith</i></p>	
<p>81. Signature of registrar: <i>John D. Smith</i></p>		<p>82. Signature of witness: <i>John D. Smith</i></p>	
<p>83. Signature of informant: <i>John D. Smith</i></p>		<p>84. Signature of witness: <i>John D. Smith</i></p>	
<p>85. Signature of registrar: <i>John D. Smith</i></p>		<p>86. Signature of witness: <i>John D. Smith</i></p>	
<p>87. Signature of informant: <i>John D. Smith</i></p>		<p>88. Signature of witness: <i>John D. Smith</i></p>	
<p>89. Signature of registrar: <i>John D. Smith</i></p>		<p>90. Signature of witness: <i>John D. Smith</i></p>	
<p>91. Signature of informant: <i>John D. Smith</i></p>		<p>92. Signature of witness: <i>John D. Smith</i></p>	
<p>93. Signature of registrar: <i>John D. Smith</i></p>		<p>94. Signature of witness: <i>John D. Smith</i></p>	
<p>95. Signature of informant: <i>John D. Smith</i></p>		<p>96. Signature of witness: <i>John D. Smith</i></p>	
<p>97. Signature of registrar: <i>John D. Smith</i></p>		<p>98. Signature of witness: <i>John D. Smith</i></p>	
<p>99. Signature of informant: <i>John D. Smith</i></p>		<p>100. Signature of witness: <i>John D. Smith</i></p>	

RECEIVED
JAN 22 1910
BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10657

CERTIFICATE OF DEATH

10666

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN lb 10 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		d. STREET ADDRESS 1 W. Baltimore St.,	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Arthur Middle G Last Sampsell		4. DATE OF DEATH Month 9 Day 22 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1885
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY D.A. Stickell	11. BIRTHPLACE (State or foreign country) Charlestown, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Sampsell		14. MOTHER'S MAIDEN NAME Nannie Fuller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-09-3051	
17. INFORMANT Norman E Sampsell		Address Jessup, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; terminal pneumonia			INTERVAL BETWEEN ONSET AND DEATH 15 days 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 8, 1958 , to Sept 22, 1958 , that I last saw the deceased alive on Sept. 22, 1958 , and that death occurred at 9:15 P.M. from the causes and on the date stated above. D.S.T. ADDRESS (Street, city or town, state) 100 Professional Arts Bldg. 9/23/58 DATE SIGNED			
ACTUAL SIGNATURE <i>W.D. Layman</i>		M.D. William T. Layman, M.D.	
PHYSICIAN'S NAME (Type) William T. Layman, M.D.		Hagerstown Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 9-25-58	22c. NAME OF CEMETERY OR CREMATORY Rest Haven	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraiss</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AT WALKER-BROOKFIELD
Weaver

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Place of death		9. Cause of death		10. Manner of death	
11. Signature of physician		12. Signature of registrar		13. Signature of informant		14. Signature of witness		15. Signature of funeral director	
16. Name of funeral home		17. Name of cemetery		18. Name of burial place		19. Name of burial place		20. Name of burial place	
21. Name of burial place		22. Name of burial place		23. Name of burial place		24. Name of burial place		25. Name of burial place	
26. Name of burial place		27. Name of burial place		28. Name of burial place		29. Name of burial place		30. Name of burial place	
31. Name of burial place		32. Name of burial place		33. Name of burial place		34. Name of burial place		35. Name of burial place	
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46. Name of burial place		47. Name of burial place		48. Name of burial place		49. Name of burial place		50. Name of burial place	
51. Name of burial place		52. Name of burial place		53. Name of burial place		54. Name of burial place		55. Name of burial place	
56. Name of burial place		57. Name of burial place		58. Name of burial place		59. Name of burial place		60. Name of burial place	
61. Name of burial place		62. Name of burial place		63. Name of burial place		64. Name of burial place		65. Name of burial place	
66. Name of burial place		67. Name of burial place		68. Name of burial place		69. Name of burial place		70. Name of burial place	
71. Name of burial place		72. Name of burial place		73. Name of burial place		74. Name of burial place		75. Name of burial place	
76. Name of burial place		77. Name of burial place		78. Name of burial place		79. Name of burial place		80. Name of burial place	
81. Name of burial place		82. Name of burial place		83. Name of burial place		84. Name of burial place		85. Name of burial place	
86. Name of burial place		87. Name of burial place		88. Name of burial place		89. Name of burial place		90. Name of burial place	
91. Name of burial place		92. Name of burial place		93. Name of burial place		94. Name of burial place		95. Name of burial place	
96. Name of burial place		97. Name of burial place		98. Name of burial place		99. Name of burial place		100. Name of burial place	

10658

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 30 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 161 SUMMIT AVE.				e. STREET ADDRESS / 111 RAT ST.			
3. NAME OF DECEASED (Type or print) First NORMAN Middle VICTOR Last SCOTT				4. DATE OF DEATH Month SEPT. Day 10 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2/25/1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER				10b. KIND OF BUSINESS OR INDUSTRY SHOE FACTORY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DANIEL SCOTT				14. MOTHER'S MAIDEN NAME MARY SNYDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no [if unknown]) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-09-5560		17. INFORMANT MR. CHARLES D. SCOTT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis - Myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio Sclerosis DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 yr +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 Sept 19 58 , to 10 Sept 19 58 , that I last saw the deceased alive on 9 Sept 19 58 , and that death occurred at 12:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE F.F. Lusby				ADDRESS (Street, city or town, state) 230 N Potomac St Hagerstown Md		DATE SIGNED 11 Sept 58	
PHYSICIAN'S NAME (Type) F.F. Lusby							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/12/58		22c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CEM		22d. LOCATION (City, town, or county) (State) SMITHSBURG MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horneant, Hagerstown, Md.				24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1033

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JOHN F. BROWN		MALE		45		JAN 15 1878		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
123 MAIN ST.		CLOCK MAKER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		DAY OF DEATH		MONTH OF DEATH	
JAN 20 1918		10:30 AM		10:30		JAN 20		JAN 1918	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1918		JAN 20 1918		JAN 20 1918		JAN 20 1918		JAN 20 1918	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10668

10659

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 day 1/2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>		e. STREET ADDRESS <u>20 W. Potomac St.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Shrader</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Silk Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Near Mercersburg Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Johnre Shrader</u>		14. MOTHER'S MAIDEN NAME <u>Maryt Ellenno Robinson (Robinson)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>214 34 0862</u>	
17. INFORMANT <u>Mrs. Almeda T. Richeal</u>		<u>10207 Newport Circle Tampa Fla.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Codwary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/13/58</u> , 19 <u>58</u> to <u>9/14/58</u> , that I last saw the deceased alive on <u>9/14/58</u> , and that death occurred at <u>9:40 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Williamsport Md</u> DATE SIGNED <u>9/15/58</u>	
ACTUAL SIGNATURE <u>Ralph F. Young</u> M.D.		PHYSICIAN'S NAME (Type) <u>Williamsport Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 16-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Lee Williamsport, Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 17 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			

CERTIFICATE OF DEATH

1922

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		REMARKS	
EDUCATION		OCCUPATION		MARITAL STATUS		RELIGION		BIRTH DATE		BIRTH PLACE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ACCIDENTS		PREVIOUS DEATHS	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA		LABORATORY DATA		RADIOLOGICAL DATA		PATHOLOGICAL DATA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL	

Item 8, Film G-234 9/25/58.cac

CERTIFICATE OF DEATH

Reg. Dist. No. 302

10660

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>15 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1616 Park Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>CROOKS</u> Last <u>SIMMONS</u>				4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 12 1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John W. Simmons</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Whithurst</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>486-07-5400</u>		17. INFORMANT <u>Mrs Marie Simmons 1616 Park Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic malignant melanoma of the lungs</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>7 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>March 11, 1958</u> , to <u>Sept. 15, 1958</u> , that I last saw the deceased alive on <u>Sept. 14, 1958</u> , and that death occurred at <u>4:40 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>148 West Washington St. Hagerstown, Maryland</u>				DATE SIGNED <u>9/15/58</u>			
ACTUAL SIGNATURE <u>B. B. Kneisley</u>				M.D. <u>B. B. Kneisley, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Age 64

1. Name of Deceased		2. Date of Death	
3. Sex		4. Race	
5. Birth Date		6. Birth Place	
7. Usual Residence		8. Cause of Death	
9. Date of Death		10. Place of Death	
11. Signature of Physician		12. Signature of Registrar	
13. Date of Death		14. Place of Death	
15. Signature of Physician		16. Signature of Registrar	
17. Date of Death		18. Place of Death	
19. Signature of Physician		20. Signature of Registrar	
21. Date of Death		22. Place of Death	
23. Signature of Physician		24. Signature of Registrar	
25. Date of Death		26. Place of Death	
27. Signature of Physician		28. Signature of Registrar	
29. Date of Death		30. Place of Death	
31. Signature of Physician		32. Signature of Registrar	
33. Date of Death		34. Place of Death	
35. Signature of Physician		36. Signature of Registrar	
37. Date of Death		38. Place of Death	
39. Signature of Physician		40. Signature of Registrar	
41. Date of Death		42. Place of Death	
43. Signature of Physician		44. Signature of Registrar	
45. Date of Death		46. Place of Death	
47. Signature of Physician		48. Signature of Registrar	
49. Date of Death		50. Place of Death	
51. Signature of Physician		52. Signature of Registrar	
53. Date of Death		54. Place of Death	
55. Signature of Physician		56. Signature of Registrar	
57. Date of Death		58. Place of Death	
59. Signature of Physician		60. Signature of Registrar	
61. Date of Death		62. Place of Death	
63. Signature of Physician		64. Signature of Registrar	
65. Date of Death		66. Place of Death	
67. Signature of Physician		68. Signature of Registrar	
69. Date of Death		70. Place of Death	
71. Signature of Physician		72. Signature of Registrar	
73. Date of Death		74. Place of Death	
75. Signature of Physician		76. Signature of Registrar	
77. Date of Death		78. Place of Death	
79. Signature of Physician		80. Signature of Registrar	
81. Date of Death		82. Place of Death	
83. Signature of Physician		84. Signature of Registrar	
85. Date of Death		86. Place of Death	
87. Signature of Physician		88. Signature of Registrar	
89. Date of Death		90. Place of Death	
91. Signature of Physician		92. Signature of Registrar	
93. Date of Death		94. Place of Death	
95. Signature of Physician		96. Signature of Registrar	
97. Date of Death		98. Place of Death	
99. Signature of Physician		100. Signature of Registrar	

APPROVED: J. M. T. HARRINGTON, M.D.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10670

10692

Item 22 Film 0234 9/24/58 ggi

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg c. LENGTH OF STAY IN 1b 1 year		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 2		d. STREET ADDRESS Route 2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roy Calvin Smith		4. DATE OF DEATH Month Sept Day 18 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1898
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Labor		10b. KIND OF BUSINESS OR INDUSTRY Industrial Machine Smithsburg Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ruben Smith		14. MOTHER'S MAIDEN NAME Margaret Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 162-09-8296	
17. INFORMANT Mrs. Emma Smith		Address Smithsburg Rt. 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic coronary heart disease 420.1 DUE TO Conditions, if any, which gave rise to the immediate cause (b) Aortic Stenosis (c) Acute Coronary thrombosis cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour None o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 9-19-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/58	
22c. NAME OF CEMETERY OR CREMATORY Ringgold Cemetery		22d. LOCATION (City, town, or county) (State) Ringgold, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		24a. REC'D BY REGISTRAR Hagerstown Md.	
		24b. REGISTRAR'S SIGNATURE DATE SEP 22 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-13. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10671

10661

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>RAYMOND</u> Last <u>SOCKS</u>		4. DATE OF DEATH Month <u>September</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 13, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>9</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Socks</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Ford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-30-9535</u>	
17. INFORMANT <u>Jack R. Socks</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Coronary & previous Cerebral Hemorrhage</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u>Hagerstown, Md.</u>	
21. I certify that I attended the deceased from <u>Dec. 5, 1958</u> to <u>22 Sept. 1958</u> , that I last saw the deceased alive on <u>1958</u> , and that death occurred at <u>6:30 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND</u>			
ACTUAL SIGNATURE <u>J. D. WILSON</u>		DATE SIGNED <u>9/23/58</u>	
PHYSICIAN'S NAME (Type) <u>J. D. WILSON, M.D.</u>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/24/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Renger</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 25 '58</u>	
ADDRESS <u>Hagerstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

525

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>7 1/2 Hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wsh. county hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dr James Earl H. Spence</u>				4. DATE OF DEATH Month Day Year <u>September 27 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 15 1896</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. AGE (In years last birthday) <u>61</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Resident Surgeon</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W.M.R.R.</u>			
13. FATHER'S NAME <u>John Spence</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-10-5015</u>			
17. INFORMANT <u>Mrs Clara O'Neill Spence</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 5</u> , 19 <u>58</u> , to <u>Sept 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 26</u> , 19 <u>58</u> , and that death occurred at <u>4:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert V. L. Campbell</u> M.D.				ADDRESS (Street, city or town, state) <u>145 W Washington St</u>			
PHYSICIAN'S NAME (Type) <u>Robert V. L. Campbell</u>				DATE SIGNED <u>9/27/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>9/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Toronto Ontario Canada</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>			
24a. REC'D BY REGISTRAR <u>SEP 29 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Andrew K. Coffman</u>			

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1. *Chlorophyll a* (Chl *a*)

...and the

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10663

CERTIFICATE OF DEATH

Reg. Dist. No.

10673

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BIG POOL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GARLOCK NURSING HOME</u>				d. STREET ADDRESS <u>1 GENERAL DELIVERY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>WEESE</u> Last <u>SPIELMAN</u>				4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>19 58</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 10, 1871</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ASHER WEESE</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>GEORGE SPIELMAN 18628 SUSEX DETRIOT, MICH.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterial Sclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2.8 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug 40</u> , 19 <u>58</u> , to <u>Sept 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 18</u> , 19 <u>58</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.				ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>9/12/58</u>			
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 22, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		22d. LOCATION (City, town, or county) (State) <u>CLEAR SPRING, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u> ADDRESS <u>CLEAR SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>SEP 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

VIN BOMER

MALE

REPORTING

Age 40

DATE

TIME

PLACE

CAUSE

MANNER

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

SEX

AGE

WEIGHT

HEIGHT

HAIR

EYES

SKIN

TEETH

NOSE

EARS

THROAT

NECK

STOMACH

INTESTINES

BLADDER

RECTUM

PELVIS

FEET

TOES

CLAWS

SKIN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10664

CERTIFICATE OF DEATH

Reg. Dist. No. 302 10674

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>MAY</u> Last <u>SPRANKLE</u>				4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 15, 1894</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sever</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Hurd</u>				14. MOTHER'S MAIDEN NAME <u>Laura Marker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-10-2665</u>		17. INFORMANT <u>Charles E. Sprankle</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular renal disease</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 7</u> , 19 <u>58</u> , to <u>September 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 11</u> , 19 <u>58</u> , and that death occurred at <u>9:05 A.M.</u> , from the causes and on the date stated above. D.S.T. ADDRESS (Street, city or town, state) DATE SIGNED <u>100 Professional Arts Bldg. 9/13/58</u>							
ACTUAL SIGNATURE <u>W. Layman</u>				M.D. <u>William T. Layman, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>				<u>Hagerstown Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/15/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer</u> <u>R. Franklin Ayres</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 16 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>William D. Hays</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10665

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 34 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. STREET ADDRESS 905 Fairview Rd.			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HARRY Middle NELSON Last STICKELL				4. DATE OF DEATH Month Sept. Day 19 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 21, 1902	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer				10b. KIND OF BUSINESS OR INDUSTRY W.Md.R.Railroad		11. BIRTHPLACE (State or foreign country) Clarke County, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Walter Stickell				14. MOTHER'S MAIDEN NAME Lily Hough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 705-10-5220		17. INFORMANT Mrs. H.N. Stickell Address 905 Fairview Rd. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Chronic Myocardial Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatitis DUE TO Shots (c) Shots							INTERVAL BETWEEN ONSET AND DEATH 5 min 4 1/2 hrs 5 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from 1934 , 19____, to 9/15 , 19 58 , that I last saw the deceased alive on 9/12/58 , 19____, and that death occurred at 7:30 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 9/19/58							
ACTUAL SIGNATURE SEARL YOUNG MD				M.D. Hagerstown Md			
PHYSICIAN'S NAME (Type) SEARL YOUNG MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/21/58		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.				ADDRESS 1601 Penna. Ave. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE SEP 22 '58	
24b. REGISTRAR'S SIGNATURE John S. House							

Wm. A. Hunt - J. P. Hunt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. RELIGION		8. MARITAL STATUS		9. EDUCATION		10. DATE OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. PERIOD OF ILLNESS		14. NAME OF PHYSICIAN		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR		17. DATE OF REGISTRATION		18. NAME OF HOSPITAL		19. NAME OF NURSE		20. NAME OF ATTENDING PHYSICIAN		21. NAME OF MEDICAL OFFICER		22. NAME OF DISTRICT MAGISTRATE		23. NAME OF DISTRICT JUDGE		24. NAME OF DISTRICT CLERK		25. NAME OF DISTRICT CHIEF CLERK		26. NAME OF DISTRICT DEPUTY CLERK		27. NAME OF DISTRICT ASSISTANT CLERK		28. NAME OF DISTRICT JUNIOR CLERK		29. NAME OF DISTRICT SENIOR CLERK		30. NAME OF DISTRICT SUPERVISOR		31. NAME OF DISTRICT INSPECTOR		32. NAME OF DISTRICT CHIEF INSPECTOR		33. NAME OF DISTRICT DEPUTY INSPECTOR		34. NAME OF DISTRICT ASSISTANT INSPECTOR		35. NAME OF DISTRICT JUNIOR INSPECTOR		36. NAME OF DISTRICT SENIOR INSPECTOR		37. NAME OF DISTRICT SUPERVISOR		38. NAME OF DISTRICT INSPECTOR		39. NAME OF DISTRICT CHIEF INSPECTOR		40. NAME OF DISTRICT DEPUTY INSPECTOR		41. NAME OF DISTRICT ASSISTANT INSPECTOR		42. NAME OF DISTRICT JUNIOR INSPECTOR		43. NAME OF DISTRICT SENIOR INSPECTOR		44. NAME OF DISTRICT SUPERVISOR		45. NAME OF DISTRICT INSPECTOR		46. NAME OF DISTRICT CHIEF INSPECTOR		47. NAME OF DISTRICT DEPUTY INSPECTOR		48. NAME OF DISTRICT ASSISTANT INSPECTOR		49. NAME OF DISTRICT JUNIOR INSPECTOR		50. NAME OF DISTRICT SENIOR INSPECTOR		51. NAME OF DISTRICT SUPERVISOR		52. NAME OF DISTRICT INSPECTOR		53. NAME OF DISTRICT CHIEF INSPECTOR		54. NAME OF DISTRICT DEPUTY INSPECTOR		55. NAME OF DISTRICT ASSISTANT INSPECTOR		56. NAME OF DISTRICT JUNIOR INSPECTOR		57. NAME OF DISTRICT SENIOR INSPECTOR		58. NAME OF DISTRICT SUPERVISOR		59. NAME OF DISTRICT INSPECTOR		60. NAME OF DISTRICT CHIEF INSPECTOR		61. NAME OF DISTRICT DEPUTY INSPECTOR		62. NAME OF DISTRICT ASSISTANT INSPECTOR		63. NAME OF DISTRICT JUNIOR INSPECTOR		64. NAME OF DISTRICT SENIOR INSPECTOR		65. NAME OF DISTRICT SUPERVISOR		66. NAME OF DISTRICT INSPECTOR		67. NAME OF DISTRICT CHIEF INSPECTOR		68. NAME OF DISTRICT DEPUTY INSPECTOR		69. NAME OF DISTRICT ASSISTANT INSPECTOR		70. NAME OF DISTRICT JUNIOR INSPECTOR		71. NAME OF DISTRICT SENIOR INSPECTOR		72. NAME OF DISTRICT SUPERVISOR		73. NAME OF DISTRICT INSPECTOR		74. NAME OF DISTRICT CHIEF INSPECTOR		75. NAME OF DISTRICT DEPUTY INSPECTOR		76. NAME OF DISTRICT ASSISTANT INSPECTOR		77. NAME OF DISTRICT JUNIOR INSPECTOR		78. NAME OF DISTRICT SENIOR INSPECTOR		79. NAME OF DISTRICT SUPERVISOR		80. NAME OF DISTRICT INSPECTOR		81. NAME OF DISTRICT CHIEF INSPECTOR		82. NAME OF DISTRICT DEPUTY INSPECTOR		83. NAME OF DISTRICT ASSISTANT INSPECTOR		84. NAME OF DISTRICT JUNIOR INSPECTOR		85. NAME OF DISTRICT SENIOR INSPECTOR		86. NAME OF DISTRICT SUPERVISOR		87. NAME OF DISTRICT INSPECTOR		88. NAME OF DISTRICT CHIEF INSPECTOR		89. NAME OF DISTRICT DEPUTY INSPECTOR		90. NAME OF DISTRICT ASSISTANT INSPECTOR		91. NAME OF DISTRICT JUNIOR INSPECTOR		92. NAME OF DISTRICT SENIOR INSPECTOR		93. NAME OF DISTRICT SUPERVISOR		94. NAME OF DISTRICT INSPECTOR		95. NAME OF DISTRICT CHIEF INSPECTOR		96. NAME OF DISTRICT DEPUTY INSPECTOR		97. NAME OF DISTRICT ASSISTANT INSPECTOR		98. NAME OF DISTRICT JUNIOR INSPECTOR		99. NAME OF DISTRICT SENIOR INSPECTOR		100. NAME OF DISTRICT SUPERVISOR	
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10666

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21 Roessner Ave.		d. STREET ADDRESS / 21 Roessner Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Ralph Yessler Stickell		4. DATE OF DEATH Month Day Year Sept. 5, 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instructor		10b. KIND OF BUSINESS OR INDUSTRY plumbing	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William H. Stickell		14. MOTHER'S MAIDEN NAME Ellen Lowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-3872	
17. INFORMANT Address Mrs. Florence L. Stickell, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Carcinoma Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 year (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-1-58 to 9-3-58 , that I last saw the deceased alive on 9-4-58 , 19 58 , and that death occurred at 2:30 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D. Hagerstown Md		DATE SIGNED [Signature]	
PHYSICIAN'S NAME (Type) Dr. E. W. Hitt		Hagerstown Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 9-7-58	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR SEP 8 '58 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Cecilia Long

6-1-24

Aggravation by
Aggravation by

The E. W. Little
Aggravation by

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10677	
Items 10,13,14, 22 Film G234 9/24/58 221											
Item 22 Film G234 9/24/58 221											
CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN b 19 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 8324 BELAIR RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First CHARLES Middle STURTZ Last STURTZ					4. DATE OF DEATH Month SEPTEMBER Day 17 Year 1958						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 18, 1888		9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR: Months 70 Days 70 Hours 70 Min. 70		IF UNDER 24 HRS. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Sturtz					14. MOTHER'S MAIDEN NAME Lillian Vinders						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL BRONCHOPNEUMONIA 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF RECTUM DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 3 YEARS											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour 19 Month, Day, Year			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from AUGUST 29, 1958 , to SEPT. 17, 1958 , that I last saw the deceased alive on SEPT. 17, 1958 , and that death occurred at 10:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE DATE SIGNED 9/17/58 ACTUAL SIGNATURE George Bercu M.D. HAGERSTOWN MARYLAND. PHYSICIAN'S NAME (Type) DR. G. BERCU											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 9/20/58		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Richard H. H... ADDRESS 7401 Belair Rd.					24a. REC'D BY REGISTRAR SEP 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10668

CERTIFICATE OF DEATH

Reg. Dist. No.

10678

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle C. L. Last Summers		4. DATE OF DEATH Month Sept Day 23 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/20/1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY real estate	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua Summers		14. MOTHER'S MAIDEN NAME Mary Elizabeth Leatherman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. John Bussard, Middletown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Prostate 177X DUE TO Intestinal Obstruction & peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 days DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchial asthma			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m. none		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 39 , 19 39 , to Sept. 23 , 19 58 , that I last saw the deceased alive on Sept. 22 , 19 58 , and that death occurred at 7:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 N. Potomac Street DATE SIGNED 9-23-58			
ACTUAL SIGNATURE S. Robert Wells		M.D. 115 N. Potomac Street	
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/25/1958	22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery	22d. LOCATION (City, town, or county) (State) Middletown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		24. REC'D BY REGISTRAR SEP 26 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hynes			

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [REDACTED]</p>		<p>AGE [REDACTED]</p>	
<p>SEX [REDACTED]</p>		<p>RACE [REDACTED]</p>	
<p>DATE OF BIRTH [REDACTED]</p>		<p>DATE OF DEATH [REDACTED]</p>	
<p>PLACE OF BIRTH [REDACTED]</p>		<p>PLACE OF DEATH [REDACTED]</p>	
<p>RESIDENCE [REDACTED]</p>		<p>CAUSE OF DEATH [REDACTED]</p>	
<p>DIAGNOSIS [REDACTED]</p>		<p>IMMEDIATE CAUSE OF DEATH [REDACTED]</p>	
<p>PERMANENT CAUSE OF DEATH [REDACTED]</p>		<p>INTERMEDIATE CAUSE OF DEATH [REDACTED]</p>	
<p>PRE-EXISTING DISEASES [REDACTED]</p>		<p>PRE-EXISTING CONDITIONS [REDACTED]</p>	
<p>PRE-EXISTING INJURIES [REDACTED]</p>		<p>PRE-EXISTING SURGERIES [REDACTED]</p>	
<p>PRE-EXISTING DRUGS [REDACTED]</p>		<p>PRE-EXISTING TREATMENT [REDACTED]</p>	
<p>PRE-EXISTING MEDICATIONS [REDACTED]</p>		<p>PRE-EXISTING THERAPIES [REDACTED]</p>	
<p>PRE-EXISTING PHYSICIAN [REDACTED]</p>		<p>PRE-EXISTING NURSE [REDACTED]</p>	
<p>PRE-EXISTING HOSPITAL [REDACTED]</p>		<p>PRE-EXISTING CLINIC [REDACTED]</p>	
<p>PRE-EXISTING LABORATORY [REDACTED]</p>		<p>PRE-EXISTING RADIOLOGY [REDACTED]</p>	
<p>PRE-EXISTING PATHOLOGY [REDACTED]</p>		<p>PRE-EXISTING PHARMACY [REDACTED]</p>	
<p>PRE-EXISTING OPTIC [REDACTED]</p>		<p>PRE-EXISTING DENTISTRY [REDACTED]</p>	
<p>PRE-EXISTING PODIATRY [REDACTED]</p>		<p>PRE-EXISTING VETERINARY [REDACTED]</p>	
<p>PRE-EXISTING AGRICULTURE [REDACTED]</p>		<p>PRE-EXISTING FISHERY [REDACTED]</p>	
<p>PRE-EXISTING MINING [REDACTED]</p>		<p>PRE-EXISTING MANUFACTURING [REDACTED]</p>	
<p>PRE-EXISTING TRANSPORTATION [REDACTED]</p>		<p>PRE-EXISTING COMMUNICATIONS [REDACTED]</p>	
<p>PRE-EXISTING EDUCATION [REDACTED]</p>		<p>PRE-EXISTING RECREATION [REDACTED]</p>	
<p>PRE-EXISTING RELIGION [REDACTED]</p>		<p>PRE-EXISTING POLITICAL [REDACTED]</p>	
<p>PRE-EXISTING SOCIAL [REDACTED]</p>		<p>PRE-EXISTING ECONOMIC [REDACTED]</p>	
<p>PRE-EXISTING ENVIRONMENTAL [REDACTED]</p>		<p>PRE-EXISTING CLIMATE [REDACTED]</p>	
<p>PRE-EXISTING GEOGRAPHY [REDACTED]</p>		<p>PRE-EXISTING HISTORY [REDACTED]</p>	
<p>PRE-EXISTING SCIENCE [REDACTED]</p>		<p>PRE-EXISTING ARTS [REDACTED]</p>	
<p>PRE-EXISTING LITERATURE [REDACTED]</p>		<p>PRE-EXISTING MUSIC [REDACTED]</p>	
<p>PRE-EXISTING THEATRE [REDACTED]</p>		<p>PRE-EXISTING FILM [REDACTED]</p>	
<p>PRE-EXISTING TELEVISION [REDACTED]</p>		<p>PRE-EXISTING RADIO [REDACTED]</p>	
<p>PRE-EXISTING INTERNET [REDACTED]</p>		<p>PRE-EXISTING MOBILE [REDACTED]</p>	
<p>PRE-EXISTING SPACE [REDACTED]</p>		<p>PRE-EXISTING ENERGY [REDACTED]</p>	
<p>PRE-EXISTING ENVIRONMENTAL [REDACTED]</p>		<p>PRE-EXISTING CLIMATE [REDACTED]</p>	
<p>PRE-EXISTING GEOGRAPHY [REDACTED]</p>		<p>PRE-EXISTING HISTORY [REDACTED]</p>	
<p>PRE-EXISTING SCIENCE [REDACTED]</p>		<p>PRE-EXISTING ARTS [REDACTED]</p>	
<p>PRE-EXISTING LITERATURE [REDACTED]</p>		<p>PRE-EXISTING MUSIC [REDACTED]</p>	
<p>PRE-EXISTING THEATRE [REDACTED]</p>		<p>PRE-EXISTING FILM [REDACTED]</p>	
<p>PRE-EXISTING TELEVISION [REDACTED]</p>		<p>PRE-EXISTING RADIO [REDACTED]</p>	
<p>PRE-EXISTING INTERNET [REDACTED]</p>		<p>PRE-EXISTING MOBILE [REDACTED]</p>	
<p>PRE-EXISTING SPACE [REDACTED]</p>		<p>PRE-EXISTING ENERGY [REDACTED]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10679

10669 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 Week</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. STREET ADDRESS <u>Millers Church Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTE LOUISE URGO</u>		4. DATE OF DEATH Month Day Year <u>September 10 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21 1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Brooklyn Kings Co N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis Meyer</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>085-05-0552</u>	
17. INFORMANT Address <u>Joseph F. Urgo Hagerstown Md R #5</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rupture of Cerebral Artery on</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-1-58</u> , 19 <u>58</u> , to <u>9-10-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-9-58</u> , 19 <u>58</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stacy Young</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown, Md</u> DATE SIGNED <u>9/11/58</u>	
PHYSICIAN'S NAME (Type) <u>S. Earl Young M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hous</u>			

CERTIFICATE OF DEATH

10680

Reg. Dist. No.

10670

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle, Penna. 75 x 3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Memorial Conv. Hospital</u>				d. STREET ADDRESS <u>231 N. Allison St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA TERESSA VARNER</u>				4. DATE OF DEATH Month Day Year <u>Sept. 29 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4, 1873</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Near Shippensburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Varner</u>				14. MOTHER'S MAIDEN NAME <u>Jane Russel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Emmet Varner</u>		Address <u>231 N. Allison St. Greencastle, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month <u>10</u>	Day <u>2</u>	Year <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Greencastle, Pa.</u>	(County) (State)
21. I certify that I attended the deceased from <u>July 1, 1955</u> to <u>Sept 29, 1958</u> that I last saw the deceased alive on <u>Sept 29, 1958</u> and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. O. Brewer</u>				ADDRESS (Street, city or town, state) <u>Greencastle, Pa.</u> DATE SIGNED <u>9/30/58</u>			
PHYSICIAN'S NAME (Type) <u>W. O. Brewer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/2/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Munich</u>				ADDRESS <u>Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaul</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 100

100-100

1. NAME OF DECEASED [Faint text, illegible]		2. SEX [Faint text, illegible]		3. AGE [Faint text, illegible]		4. DATE OF BIRTH [Faint text, illegible]	
5. PLACE OF BIRTH [Faint text, illegible]		6. OCCUPATION [Faint text, illegible]		7. MARITAL STATUS [Faint text, illegible]		8. COLOR [Faint text, illegible]	
9. CAUSE OF DEATH [Faint text, illegible]		10. MANNER OF DEATH [Faint text, illegible]		11. PLACE OF DEATH [Faint text, illegible]		12. DATE OF DEATH [Faint text, illegible]	
13. SIGNATURE OF PHYSICIAN [Faint text, illegible]		14. SIGNATURE OF REGISTRAR [Faint text, illegible]		15. SIGNATURE OF WITNESS [Faint text, illegible]		16. SIGNATURE OF DECEASED [Faint text, illegible]	
17. SIGNATURE OF DECEASED [Faint text, illegible]		18. SIGNATURE OF DECEASED [Faint text, illegible]		19. SIGNATURE OF DECEASED [Faint text, illegible]		20. SIGNATURE OF DECEASED [Faint text, illegible]	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10671

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 4 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS R # 6	
3. NAME OF DECEASED (Type or print) First Ira Middle S Last Weber		4. DATE OF DEATH Month Sept. Day 22 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1896
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Wash. County, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin Weber	
14. MOTHER'S MAIDEN NAME Anna Martin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Leah Weber- R # 6 Hagerstown, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Open Fracture skull DUE TO Multiple fracture of ribs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration of lung DUE TO Fracture Synthesis Pubis (c) Hemorrhage and shock			INTERVAL BETWEEN ONSET AND DEATH 4hrs 45Min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while inspecting a roof that was leaking	
20c. TIME OF INJURY Month, Day, Year 9:45 a.m. Sept. 22 '58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Rural Hagerstown Wash Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-23-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-25-58	22c. NAME OF CEMETERY OR CREMATORY Reiff Cemetery	22d. LOCATION (City, town, or county) (State) Near Cearfoss Wash Md
23. FUNERAL DIRECTOR'S SIGNATURE A. E. Minnich Greencastle, Pa		24a. REC'D BY REGISTRAR DATE SEP 26 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10682

10693

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wash	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R # 2		e. STREET ADDRESS R # 2	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edgar Middle James Last Weller		4. DATE OF DEATH Month Sept. Day 16 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13. 1900
9. AGE (In years and month) 58 yrs. 8 months 23 days		IF UNDER 1 YEAR 23 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Orchard	11. BIRTHPLACE (State or foreign country) Washington County
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert L Weller	
14. MOTHER'S MAIDEN NAME Hester Younker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 218-01-1855		17. INFORMANT Mrs Della Weller Rural 2 Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot wound into chest and left axillary region 976X DUE TO Hemorrhage and shock (shotgun) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 10 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest with 12 gauge shotgun	
20c. TIME OF INJURY Month, Day, Year 12:30 9-16 58	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Rural Hancock Wash, Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Weller		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Weller, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9.19.58	
22c. NAME OF CEMETERY OR CREMATORY Stone Bridge Cemetery		22d. LOCATION (City, town, or county) (State) Near Hancock Washington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Shore		24a. REC'D BY REGISTRAR SEP 23 '58	
ADDRESS Hancock Md		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10672

CERTIFICATE OF DEATH

10683

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2401 Virginia Ave.</u>				d. STREET ADDRESS <u>2401 Virginia Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Gilbert</u> Last <u>Wigfield</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>15</u> Year <u>58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24 1891</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>21</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa. Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wilson Wigfield</u>				14. MOTHER'S MAIDEN NAME <u>Malinda Hiles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>717 07 9260</u>		17. INFORMANT <u>Mrs. Leila Wigfield</u> Address <u>2401 Va. Ave. Hagerstown Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-15-58</u> , 19 <u>58</u> , to <u>9-15-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-15-58</u> , 19 <u>58</u> , and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u>		DATE SIGNED <u>9/15/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. E. W. H. T. To</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 17-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williams</u>				ADDRESS <u>[Signature]</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

10673

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 836 Virginia Ave.		d. STREET ADDRESS 1 836 Virginia Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle Belle Last Williams		4. DATE OF DEATH Month September Day 26 , Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1866
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Phillip Burton		14. MOTHER'S MAIDEN NAME Elizabethh McBride	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. William Kallmyer, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) due to general & cerebral arteriosclerosis DUE TO (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 24hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia - bilateral		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 25, 1958 , to Sept 25, 1958 , that I last saw the deceased alive on Sept 25, 1958 , and that death occurred at 4:12 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward W. Ditto III		ADDRESS (Street, city or town, state) DATE SIGNED 212 W. Washington, York St 9/26/58	
PHYSICIAN'S NAME (Type) Edward W. Ditto III, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-29-58	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR SEP 30 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10685

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>LOUISE</u> Last <u>ZELLER</u>				4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13 1890</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ladies Clothes</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bruce Scott Zeller</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Zeller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-3269</u>		17. INFORMANT <u>Mrs Virginia L. Smith</u> Address <u>809 Guilford Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Garcinoma of the liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 18, 1958</u> to <u>Sept. 13, 1958</u> , that I last saw the deceased alive on <u>Sept. 11, 1958</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>148 West Washington St. Hagerstown, Md.</u> DATE SIGNED <u>9/15/58</u>							
ACTUAL SIGNATURE <u>B. B. Kneisley</u> M.D.				PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, N.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem E. & R Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneisley</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

